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ABSTRACT

The theme of this issue of a journal designed to focus on the prevention of various kinds of substance abuse is "children of alcoholics" (CoAs). The lead article, "Children of Chemical Dependency: Respecting Complexities and Building on Strengths," by Pamela Woll, examines chemically dependent family systems. The article begins by offering two sets of recommendations for prevention practitioners, the first concerning the vision needed by program leaders in the prevention field, and the second concerning things to keep in mind in program content, such as the need to have ongoing support systems in schools. The remainder of the paper is given over to 15 detailed recommendations for studying about children and families in the context of chemical dependency. Information from the National Association of Children of Alcoholics lists facts regarding CoAs. The addresses of state chapters of the National Association of Children of Alcoholics are listed. The text of the 1990 Sir Charles Burns lecture presented by Jeanette L. Johnson in New Zealand, which states the front page with the article by Woll, provides a general overview of children and the effects of coming from an alcoholic family. The feature piece of this issue, entitled "Children of Alcoholics: Are They Different?" examines differences between children of alcoholics and others as well as the fact that alcoholism tends to run in families. In a separate "box," 17 general themes and approaches for communicating to children of alcoholics and other drug-abusers are listed. "Provide positive alternatives," and "Channel aggression to less harmful behaviors are among recommended approaches, and it is also observed that multiple media approaches appear to be popular for reaching teenage audiences, and that "personal relationships are important in communicating with high-risk youth." A concluding article by Nancy Phillips, "Creating Change for Healthier Youth: Strategies for Living with Alcoholism" is addressed directly to youth in the pre-teen to mid-teen years, and makes the point that accepting alcoholism as a disease is vital to releasing guilt and anger and realizing no one is to blame. (ABL)

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Children Of Alcoholics

Text Of 1990 Sir Charles Burns Lecture Held At NASD Workshop In New Zealand

The following is the text of the Sir Charles Burns Lecture, given at the National Society on Alcoholism and Drug Dependence Workshop, Royal Police College, New Zealand, on January 17, 1990. The lecture was delivered by Jeannette L. Johnson, Ph.D., and is printed through the permission of Roy Johnston, National Society on Alcoholism and Drug Dependence, New Zealand.

Thank you for inviting me to give the Sir Charles Burns Lecture. I am delighted to be back in New Zealand and honored to be a part of the academic history of excellence created by Sir Charles Burns. Sir Charles Burns was obviously a man with a vision; a vision which encompassed a feeling of responsibility for humankind. Whether it is personal, social, or world change we envision, we need to have one in order to work towards our future dreams and goals. Visions become necessary for change; they not only shape the possibilities of our dreams, but they also shape the possibilities for the dreams of our future generations. The importance of the Sir Charles Burns Lecture is in its contribution to maintaining the vision that Sir Charles Burns himself was dedicated. I am privileged to be among those who have come before me.

Unfortunately, children who are raised by alcohol and drug abusing parents must alter their future goals and visions according to many factors of their biological and environmental heritage. Today, I will discuss the many obstacles that children of alcohol and drug abusing parents must overcome in order for them to create their own

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Children Of Chemical Dependency: Respecting Complexities And Building On Strengths

By Pamela Woll

Note: *Pamela Woll is the Senior Writer, Prevention Resource Center, Chicago Office.*

"When I was growing up in an alcoholic home, one of the things that I was acutely aware of was that when I felt sad, or angry, or panicked, or hurt, there was no place — and no one — where I was safe enough to talk about how I felt.

"I also noticed something else: that when the adults in my life had the same feelings, they did something to make those feelings go away. They used a chemical, they used food, they used 'busy-ness,' they used control and management of themselves, others, and situations.

"I really believed that noise and upsetting and making people uncomfortable was what made things so bad in my house. So I spent my life trying never to make noise and always to be good, and never making anyone uncomfortable. And it didn't work.

"And I found alcohol, and it worked.

"It's amazing how well that stuff works. I spent 11 years of my life without it, and at 11 I put it in my body and I became who I had wanted to be. It was amazing, and it was free. Alcohol was the only thing that made a great deal of sense to me. Had you been there to try to talk me out of using alcohol, I want to assure you that you would have been ignored and probably ridiculed.

"But had you been there to tell me you cared what I was feeling, you might have made all the difference. Had you been there to tell me you might even know a little bit of what I was feeling, I might have believed that there was some human being in the world I could count on."

— Cathleen Brooks

In prevention, we're in the process of building our vision of health and wholeness, properties that we seek to promote and support in the lives of children, adults, families, communities, workplaces, and other systems. As much as our realism permits, we keep a positive focus.

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Children Of Chemical Dependency *continued*

First among the negative patterns that we seek — not only to prevent, but really to replace — is the abuse of alcohol and other drugs. But we find we can't address that problem without taking into full account the process of chemical dependency, with all its power, deception, complexity, and tenacity in following families from generation to generation.

The scope of our primary prevention work includes people who are not yet dependent on alcohol and/or other drugs. But within that scope are many of the one out of five children in every classroom estimated to live in chemically dependent and codependent families — families molded around the pain, denial, and confusion of that disease. Our scope also includes countless adults who were raised in chemically dependent and codependent homes. Although they may have escaped active substance addiction, many carry the genetic predisposition toward it, along with self-defeating and/or self-destructive attitudes and life patterns — a dangerous legacy for their children.

For many of these children and adults, breaking the generational chain will require a lifelong healing process similar to recovery from chemical dependency. But even the process that leads to the beginning of recovery can be a long one, a gradual absorption of information and insights. It can start in small and simple ways, like a piece of information picked up in school, or a look of understanding from a friend. If we are to play our most effective part in this powerful form of prevention, we need to know all we can about addictive/codependent family patterns, the momentum of addiction through generations, and how recovery works. With this in mind, the Illinois Department of Alcoholism and Substance Abuse (DASA) is focusing this year on building our ability to know and meet the needs of children raised in chemically dependent families.

In August of this year, DASA held its Seventh Annual Illinois Institute on Drugs and Alcohol (IIDA) in conjunction with the Sixth Annual Convention of the National Association for Children of Alcoholics (NACoA). Called "Joining Hands to Heal," it was an unprecedented chance for those two diverse and highly respected bodies to share knowledge, experience, understanding, ideas, support, vision, and hope. This article is a result of that conference. Its assertions and recommendations are fused from ideas and insights provided by the speakers there, and in many cases illustrated by words from their presentations, or from conversations with them. Because the focus is on children of chemically dependent families, it relies primarily on the words of speakers brought in by NACoA, a unique opportunity for IIDA audiences.

The depth of our understanding will tell us what to say and what not to say, how to do the most good and the least harm

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Although many of the IIDA and NACoA speakers contributed information to the article, the direct quotations were taken from Claudia Black's presentation on the added burdens and complexities that confront many adult children, and her workshop on shame and guilt; Cathleen Brooks' presentation of information that the children of alcoholics field can offer to the chemical dependency field; Stephanie Brown's presentation on future directions; Ruth Davis', Jerry Moe's, and Ellen Morehouse's workshop on NACoA's Elementary School Project; James Dempsey's, Ron Figueroa's, and Lottie Jones' workshop on ethnic and cultural diversity; Betty LaPorte's workshop on surviving childhood abuse; and Jerry Moe's presentation on recovery for children. (Brief biographies of the people quoted are at the end of the article.)

The following takes the form of two sets of recommendations for the prevention field as we work to make our programs responsive to the needs of children of chemically dependent families. The first set concerns our study of children and families, and the second concerns the words and programs we present.

In looking at chemically dependent family systems, and the needs of the children affected by them, our vision must be:

1) Sophisticated enough to respect the complexity and variability of the disease of addiction and codependency — its ability to hide under surface functionality, the sophistication of its denial process, and the varying degrees to which it affects families;

2) Long enough to see the generational momentum of the addictive/codependent process throughout the history of the family, carried not only in genetic factors and learned behavior, but also in attitudes and patterns;

3) Broad enough to take in the whole family system — with all its complexities and contradictions, balance and imbalance — not just the identified chemically dependent parent(s);

4) Flexible enough to consider any additional negative dynamics, in the family or in the surrounding systems, that might compound the effects of the chemically dependent system;

5) Deep enough to focus on the core issues — components of health that have not been allowed to develop naturally in children's lives and the self-defeating attitudes and patterns that have developed in their absence — and the connection between that pain and the risk or reality of destructive life patterns;

6) Searching enough to seek out information from the many related fields — including treatment, mental health, child abuse prevention, and 12-step recovery programs — and to envision and collaborate on inter-disciplinary efforts; and

7) Open enough to honestly assess and continue to work on our own growth, health, and wholeness, and to understand that our success in promoting health and respect will depend more than anything else on our success in modeling those qualities.

In the words and programs we present to children, parents, educators, and communities, we need to keep these things in mind:

Children Of Chemical Dependency *continued*

8) The fact that the amount of trouble children are causing for adults is not a reliable indicator of how troubled they or their families really are, or how severe their problems will be in the future;

9) The need to give general audiences of children carefully prepared information about chemically dependent families and their effects on children, knowing that our success in doing so will benefit all children;

10) The vulnerability to a sense of "shame" or worthlessness that children can develop in chemically dependent families, and the danger that our words and actions might reinforce that shame through careless or judgmental approaches;

11) The importance of denial and other survival systems in the emotional — and sometimes physical — well-being of children of chemically dependent families, and the need to allow children to leave those survival systems intact;

12) The need to have ongoing support systems in schools before we do anything that might raise children's awareness of chemical dependency in their own families;

13) The need to make all of our prevention programs respect the realities in which children live, including children of chemically dependent families;

14) Our opportunity to supplement the growth of health and wholeness by teaching children and adults about core components of healthy self-esteem that often get lost or distorted in troubled families — things like healthy boundaries, age-appropriate expectations, acceptance, detachment, direct communication, living in the present, and taking care of oneself; and

15) The strengths, resources, and resiliencies already available in children, families, recovery programs, and cultural heritage, and the importance of emphasizing these positive elements, and the hope that they represent.

Most often the words "addiction" or "chemical dependency" will be used in this article, because they are inclusive, covering addiction to alcohol and other drugs. With the increased availability of cocaine in the form of crack, and the steadily increasing numbers of people who are dependent on both alcohol and other drugs, the profile of the chemically dependent family is changing, even if the disease remains the same.

At times those words will be coupled with the words "and co-dependency," to underscore the crucial role that codependency plays in passing on addictive attitudes and patterns. Codependency is defined and described in many ways, among them as an obsessive tendency to deny one's own needs and focus on, deny, and/or try to "fix," someone else's problems — to the point of unconsciously seeking out people with those problems over time.

A child's pain, in and of itself, is worthy of attention

Codependency can be a response to the pain caused by someone else's addiction, and/or a pattern learned from a codependent role model. It does not cause the disease of addiction to occur, in the individual or in the surrounding system, but it is the most common response to another's addiction, and the response most likely to aggravate and sustain it. It is considered by many to be both the counterpart to chemical dependency and the ground in which it most easily grows.

Codependency is no longer seen as the exclusive domain of the spouse or child of the chemically dependent family member. It is a way of thinking, feeling, and interacting that people with and without chemical dependencies take on in greater or lesser degrees. It easily exists along with chemical dependency in the same individual.

When the word "blackout" is used, it will refer to the state of inebriation where people are conscious — capable of walking, talking, and engaging in other activities — but once the effects of the chemicals have worn off they have no memory of what happened during that time.

The article, and many of the speakers quoted, will also mention the process of "recovery." This refers to the ongoing, lifelong process of recovery from addiction and its effects on families and friends, rather than to any specific clinical function, like treatment or therapy. On the continuum of care (prevention, intervention, treatment, and aftercare), recovery is considered a subsection of aftercare. Although the term "aftercare" generally refers to clinical therapy and relapse-prevention programs that help people for a period of time after they leave treatment, on the continuum of care the category "aftercare" is used to include both post-treatment clinical services and the mutual-help groups (usually 12-step groups, Alcoholics Anonymous, and others which follow its model) that support lifelong recovery.

The object of the study and focus recommended in this article is an understanding that reaches beneath and beyond the formulas often used to describe and explain the issues that surround chemically dependent families. The depth of our understanding will tell us what to say and what not to say, how to do the most good and the least harm.

Our opportunity to be of service is very powerful, partly because of the training and information we will be receiving from DASA in the months to come, but also because of the positive stance we've been cultivating in prevention: our vision of health and wholeness. Children of chemically dependent families already know how to focus on the negative. They've received lifelong training in that. What they need are people who convey sincere empathy for the pain these children might be living, and still affirm their worth and believe in their strength, resiliency, and potential for full health.

We can resemble the traditional "healer" whom Ron Figuera described in a workshop on ethnic and cultural diversity. "The healer is caring and empathetic. The healer has the ability to listen and hear the pain without succumbing to it or losing hope.

"In the most hopeless of situations, the healer exemplifies hope."

continued

Children Of Chemical Dependency *continued*

Recommendations For Studying About Children And Families

1. RESPECT THE COMPLEXITY AND VARIABILITY OF THE DISEASE

No other reality puts twists and turns in our thinking and feeling like the phenomenon of chemical dependency and the way it affects the people around it. More than any other factor, it confounds our attempts to draw a straight line between "healthy people" and "unhealthy people."

Other diseases may lie hidden or dormant for years or generations, but they don't carry anywhere near the degree of denial, deception, and shame that seems to hold this one together. When most people feel the pain of other diseases, they seek help. Not so with this one. When the internal sense of shame or worthlessness — bound up in the denial that pervades individual and family life — meets the outside senses of moralism, disapproval, and denial that are the legacy of society's incomplete understanding of this disease, it seems much more dangerous to acknowledge the pain than to retreat back into it.

When we consider the needs and risks of children of chemically dependent families, we juggle a number of largely visible factors:

- The absence or presence of genetic predisposition toward addiction, something we still can only guess at in any individual;
- The degree to which children have begun to feel that they are essentially worthless — a progressive time-bomb that often doesn't show from the outside but, although it doesn't cause addiction, can easily lead to substance abuse and other destructive life patterns;
- The degree to which children have not learned to take care of themselves in important ways, often hidden under an exceptional ability to put on a good front and to take care of others; and
- The strengths and resiliencies already existing in these children, and in their families.

If our charge includes all people for whom destructive life choices are still preventable, then it includes many children of chemically dependent families. Our first step in helping might be to discard any notions of "healthy people" and "unhealthy people," or "healthy families" and "unhealthy families." If instead we think — and speak — in terms of healthy and unhealthy attitudes and patterns that people and families have, we will be more accurate, avoid negative labeling, and do more to promote both unity and healthy change.

Human dependency exists on a continuum, with the healthy interdependency of all beings at one end, and things like addiction and isolation at the other. We all live on that continuum, and even the people and families in whom health is strongest have stressful situations in which they need to seek help. "When we look at families we have a tendency — particularly those of us who are raised in dysfunctional families — to think in 1s and 10s," said Betty LaPorte in her workshop on surviving the effects of childhood abuse. "And so we think there are good families and bad families. But there's varying degrees of dysfunction in families."

All the normal developmental paths of childhood become sacrificed to preserve the drinking

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In the confusion that comes out of family troubles, there's a temptation to paint things black and white, or to look for some formula that will make it all understandable. Among the first — and sometimes the only — information people receive on the subject are the roles and "characteristics" taken on by children of chemically dependent families. In her discussion of future directions for the children of alcoholics (CoA) movement, Stephanie Brown asked that people be careful not to think or speak of these formulas in absolute terms.

"We have grown up slotting ourselves in certain roles in the family, which is very accurate, and is a systems perspective," said Brown. "Very important, the work of Claudia Black and Sharon Wegscheider, outlining the roles that children would assume in the family. And what happened at the popular level? We all embraced those roles. In helping ourselves to see how we had accommodated to the trauma, to the environment in the pathological system, we then got stuck in those roles and couldn't get beyond it.

"Another example of that overgeneralization and oversimplification comes in the six, 10, 13, 33, 180 'characteristics' that we all share as children of alcoholics. Again, this is a tremendous strength. But the trouble is that these characteristics are part of *all* human behavior." The attitudes and patterns that children in troubled families take on — like addictive attitudes and patterns in general — may be quantitatively different from those at work on people unaffected by addiction, but they are not qualitatively different. "What we want to understand is how these defensive maneuvers might be overused in a negative way," said Brown, "and not how they differentiate children of alcoholics from other people." Even the use of the words "characteristics" or "traits" can be dangerous, making them seem like ingrained and indelible qualities — what people are, instead of what they do, said Brown. "What you may refer to as 'characteristics' I see more as defensive manuevers."

2. SEE THE GENERATIONAL MOMENTUM OF ADDICTION AND CODEPENDENCY

While it might be our worst mistake to view children of chemically dependent families coldly and clinically as "carriers of the disease," no study of this subject will be effective unless we take into account the generational cycle of addiction. It would be both inaccurate and counterproductive ever to "blame" one generation for chemical dependency in the next, or to say that addiction and

Children Of Chemical Dependency *continued*

addictive attitudes can always be traced to parents and their parents. But the cycle has generated too much evidence to ignore, and an objective focus on it will bring us closer to a true understanding of the problem at hand.

"In the last year, there've been about 20 parents who came to our program, and they've said, 'I can't stop, but would you help my child?'" said Jerry Moe in his presentation on recovery for young children. "The reason is invariably the same: 'When I look at him, and I look at her, I see myself when I was eight years old and 11 years old, and it's so painful, I don't want them to go through what it is I'm going through.'"

To understand the momentum of addiction through family history, it will be necessary to see far behind and beyond the children currently or at one time living with addicted parents. "We are talking about generations," said Cathleen Brooks in her presentation of information gained by the CoA movement, "generations of children who are still being impacted by the legacies of 'You don't matter. You're not important. Gear up, get with the system. Don't make too much noise. Don't laugh.' Large numbers of people have been wounded by these childhood losses that we are here to talk about at this conference. Their wounding does not magically disappear. It simply becomes more intense and less 'fixable' as time goes on.

"And one day a mother may be sitting in your office, crying about her son who's using drugs, and you may be tempted to focus on how to get that son to stop using drugs, and not see the tears of that mother, and not ask yourself, 'Is she reliving a nightmare that she had when she was a child?' And so you have to think quickly about grandchildren and great-grandchildren, and to see this family as a generational legacy, and see yourself in that incredible moment in time — what I call a miracle moment — where you can say 'I'm going to do something more than my job here.'"

Brooks described that moment as the chance to reach beyond the topic at hand, and with care and empathy answer the question behind the mother's tears: "'Are you going to be the one who's finally going to feel my pain? Because if you don't, it doesn't matter what you do for my son.' The wounding is still there, and it will go on generation after generation, because I'm going to tell you a secret: She may have been sober when she raised her son, but she wasn't well. She wasn't able to give him what he needed, because it wasn't given to her."

Brooks challenged her audience not to think of children's or adults' needs just in terms of the problems they are causing, but to ask themselves this question: "What can I do to begin with my behavior and my words to give a clear message that a child's pain, in and of itself, is worthy of attention — that we need not wait until that pain becomes so great that the child takes it upon him- or herself to medicate it with chemicals or some other behavior that bothers us?

"And that child's pain does not end when childhood ends. It is carried on into adulthood, often manifesting itself in adult-onset alcoholism; often manifesting itself in marriages to

continued

Just Some Facts —

Information From The National Association For Children Of Alcoholics

Because one in every eight Americans is the child of an alcoholic, CoAs are not a small minority. JUST SOME FACTS:

- Children of alcoholics are at a higher risk than children of non-alcoholics for alcoholism or marrying into a family in which alcoholism exists.
- Children of alcoholics have two to four times greater risk of alcoholism than children of non-alcoholics.
- There is an increased prevalence of alcoholism among child abusing parents.
- Children of alcoholics exhibit symptoms of depression and anxiety more than children of non-alcoholics.
- It is estimated there are approximately 28.6 million children of alcoholics in the United States; 6.6 million are under the age of 18 and live with a practicing alcoholic(s).
- Fetal Alcohol Syndrome is the leading cause of retardation in the United States today.

As youngsters, these children may be more likely to: do poorly in school, be truant or delinquent; use alcohol or drugs; be neglected or abused; feel lonely, unloved, or frightened, and have few friends.

As adults, children of alcoholics may suffer from alcoholism or physical or mental illness, or may be rigidly controlled overachievers who suffer depression in mid-life.

Alcoholism runs in families, continuing the cycle on to future generations. As we enter the 21st century, NACoA's vision is to motivate caregivers to intervene in the life of a child of an alcoholic or other drug abuser. Women are the prime targets of the campaign to save the children.

Children Of Chemical Dependency *continued*

alcoholics, addicts, gamblers, other dysfunctional situations; manifesting itself sometimes in work situations that are destructive, compulsive, addictive; manifesting itself in a whole range of stress-related disorders. And most importantly, manifesting itself in communities of adults who — having never been children, and having never known what it was to be parented lovingly and unconditionally — cannot do it for their own children."

3. TAKE IN THE WHOLE FAMILY SYSTEM

Although the words "chemically dependent family" don't tell us what a given family looks like, acts like, or feels like, they can conjure up an eloquent and profoundly affecting set of images. Whether or not we have lived with chemical dependency, we have all heard enough to respect its destructive potential. Presenters at the IIDA/NACoA conference illustrated their points sparingly, with a selection of brief but searing glances. For example:

- The seven-year-old boy who eagerly woke his father up for the promised fishing trip, the first in his life, then was forced to deal alone with his hurt, anger, and confusion when his father — who had made the promise in a blackout — asked him, "What the hell are you talking about?" and his mother, who'd been sober when the promise was made, simply told him to go back to bed;
- The five-year-old girl who consistently expressed shame and self-recrimination that her 17-month-old brother, who spent most of his time in her care, still had diaper rash; and
- The four-year-old boy who stood guard on the porch while his mother shot heroin at her connection's house, then sat on two thick phone books beside her on the ride home, so he could pat her on the face periodically to make sure she didn't nod out.

Any attempt to portray a "typical" chemically dependent family would be an oversimplification, a disservice to the families living with the disease. Some families function quite well most of the time, and trouble plays only an episodic role; in others, everyone is very well behaved, and all that the disease blocks is communication and closeness. At the other end of the scale live the horror stories, and they definitely do exist. But when we think about what happens in families, it's important to remember that addiction is a disease — and so, many believe, is codependency. No one chooses to be afflicted.

In our efforts to help children of chemically dependent families, we don't have to focus on the problems, or on the identified chemically dependent parent(s). The family system is already well organized to do just that. "Our families, rather than being support or affirmation focused, are problem focused," said LaPorte. "The alcoholic family system is organized to deny the reality of alcoholism, while preserving it at the same time," said Brown. "Individual development, healthy perception, healthy, logical operations — all the normal developmental paths of childhood — become sacrificed to preserve the drinking. The focus is on the alcoholic, and the rest of the family is sacrificed."

One of the by-products of this disease is that love never gets expressed in a consistent fashion

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In a workshop on shame and guilt, Claudia Black described four conditions often found in troubled families. "What I call a 'troubled family' is a family affected by isolation, rigidity, denial, and shame," said Black. "It's emotional isolation as much as it is social isolation. Rigidity in the structure of the family, in terms of role expectations, how people think. In a family that operates in denial, it's not okay to talk honestly about what it is that's going on in the family. And a family where children learn there's something wrong with who they are."

Those conditions don't negate, but often confuse, the love that exists in families. "In 14 years of working with addicted families, I've never met a family where everyone didn't love everyone else," said Moe. "But one of the by-products of this disease is that love never gets expressed in a consistent fashion. And virtually every child I've worked with somewhere in the back of their mind are gnawed by that question: 'Do they love me? Why don't they always show it? What can I be doing differently?'"

4. CONSIDER ANY ADDITIONAL NEGATIVE DYNAMICS

If other dynamics also exist that can tend to produce pain, shame, or isolation, children's troubles can be compounded. "Double duty" is the term that Black has coined to describe some forms of this condition. "Simply put, double duty refers to added complexity, added trauma," said Black in a presentation on that concept. "Double duty exists when a child has one major trauma-inducing dynamic in their life, and an additional dynamic comes in and reinforces those consequences." The examples Black gave of double duty experiences in chemically dependent homes included being the only child, being gay or lesbian, having physical disabilities, having two chemically dependent parents, and being the victim of physical, sexual, or emotional abuse.

Of children in these and other double duty situations, Black said, "In order to survive, what we've had to do is to toughen up, these kids more so than other kids. As a group, they experience far greater shame, and I believe that they have a need to walk through the grief part of recovery more slowly."

Although the conference focused on children of chemically dependent families, several speakers mentioned that families without that particular dynamic can also experience stress and dysfunction at mild or severe levels. The effects of other troubles on the family system may or may not resemble those of chemical dependency, but children's experiences can be traumatic, and can interfere with healthy development. Examples of other negative dynamics included other illnesses in the family, physical or mental; physical, sexual, or emotional abuse (more common

Children Of Chemical Dependency *continued*

among chemically dependent families but certainly not limited to them); serious financial problems; religions that emphasize shame and guilt; separation and divorce, and the years of marital discord leading up to those steps; and parents' addiction to processes like work, gambling, sex, or overeating.

And finally, if a sense of worthlessness within the family system is reinforced in outside systems, the child's burden can be greater than the sum of its parts. This can include communities where poverty or oppression have led people to give up hope, or schools where children are not treated with respect or are actually abused, physically, sexually, or emotionally.

The consequences to shame are many, from blatant, chronic victimization to self-abuse, to the abuse of others

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By far the most common example of systemic reinforcement is racism. In the cultural diversity workshop, Lottie Jones described her family, which sometimes functioned well and sometimes functioned badly, because of a preoccupation with an outside force, alcoholism. It failed to validate her thoughts and emotions, left her confused, and taught her not to talk, not to trust, and not to feel. "I also grew up in another dysfunctional system," she said. "It was a larger family. It was a larger unit called society. It was functional in some ways, and in other ways it was not. This family is and was unable to function in a healthy way because of a preoccupation with an outside force. That force is racism.

"It was a family where I was confused. My natural reasoning process told me one thing. The people in authority, the larger society, told me something else. And then nobody would validate what I felt. Everybody was caught up in it, and I had no place to turn. The people in authority were caught up in it, and my fellow Blacks were caught up in it. And we were all confused. So I developed a mechanism to cope with it. The mechanism I developed was, 'Don't talk about it. Don't trust any of them because they will get you. And don't feel, because it's too painful.'"

5. FOCUS ON THE CORE ISSUES

Where is the child in all this? What's missing from the mix of love and instruction that was meant to surround the child as a healthy human being was formed? What essential elements of human development does the child have to give up in order to survive and function?

Throughout the presentations at the conference ran one central theme: that addictive systems interfere with the development of a healthy sense of self-worth. The hole where that essential quality was supposed to have developed is often called "shame." The sense of self-worth — of wholeness, of completeness, of having a right to exist — is something that families functioning at their ideal capacity naturally instill in children. In these situations adults are free to show consistent love and respect, to be honest and dependable, and to clarify and respect the "boundaries" between their own lives and those of the people around them. A child's sense of self-worth simply develops.

In the tangle of the troubled family system, important things get distorted or discarded. Love is there — often in great measure — but the pain, rage, and obsessiveness of the addictive/codependent process can sometimes drown it out, so that it feels to the child like hatred or indifference. "Almost always when you pull away the layers of shame I think you will find abandonment at the foundation," said Claudia Black. "And that abandonment can be either physical or emotional, and oftentimes both. This abandonment is typically on a chronic basis, the message being, 'You're not important. You're in the way. You are not of value.'"

How well the child is able to detach from these messages will depend on the child's ability to differentiate his/her life, worth, needs, perceptions, control, and responsibilities from those of the people who are sending the messages, said Black. "One needs to have a sense of oneself separate from others, and one needs to have a sense of self-worth, to be able to reject shameful messages."

Unfortunately, one of the most common effects of chemical dependency on family systems is a breakdown, distortion, or rigidity of the "boundaries" that were meant to be clear and flexible — to outline people's lives and responsibilities, all interdependent but each essentially whole. For example, if a chemically dependent and/or codependent parent is consistently blaming others for his/her problems; if a codependent parent is ignoring his/her own needs and trying to "fix" the other parent; or if one or both parents are trying to change, control, or manipulate the child in excessive, inappropriate ways, the child will not develop a clear sense of where s/he ends and other people begin.

"When a child lives with abandonment, be that emotional or physical, plus distorted or undefined boundaries — particularly at a time in their life when they're developing their worth — that will result in shame," said Black. "The consequences to shame are many, from blatant, chronic victimization to self-abuse, to the abuse of others." In a workshop on shame, Black talked about some of the most common consequences, including preoccupation with control, taking a victim's stance, engaging in apathetic rela-

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Children Of Chemical Dependency *continued*

tionships, addiction to rage, perfectionism, compulsive behaviors, addictive behaviors, and suicide. The "grandiosity" so characteristic of the addictive personality is rooted in shame.

For the child living in an afflicted home, surrounded by contradictions — love and abandonment, the obvious and the denial of it, basic human needs and the neglect of those needs — several important adjustments are necessary for emotional survival. One of these is an ability to be selective about trust, or to live without trusting anyone. Another is denial.

Denial has as many definitions as people defining it. One would be that denial is the ability both to know something and not to know it, to look straight at it without seeing it. For the child in the chemically dependent home, reality seems to conflict with itself. When the pain of this conflict becomes too great, the child learns to split reality, and to hold conflicting versions of the truth without letting them interfere with one another. This ability isn't limited to the child's perception of the parent's use of substances. It's a necessary survival skill that affects many areas of the child's life and perceptions, and is carried into adulthood. It might eventually include denial of one's own or one's partner's self-defeating or self-destructive patterns. Whatever its later consequences might be, to the child in the chemically dependent home, denial is necessary for survival.

One common result of the shame, abandonment, distorted boundaries, and denial is a deep sense of loneliness and isolation. In some very tangible senses children can be separated from themselves, from their own perceptions, from other members of their families, and from the outside world that must never know what family life is really like. The enmeshment that sometimes happens in families where boundaries are not well defined serves to reinforce the isolation, rather than break it: isolation can seem like the only available defense. "I believe the loneliness and isolation that children of alcoholics experience is invisibly intertwined," said Black. "I find that loneliness is more internal, a feeling that's experienced mixed with great sadness. Isolation I believe to be more external, like an invisible but ever-present wall that exists."

6. SEEK OUT INFORMATION FROM RELATED FIELDS

One clear message of the "Joining Hands to Heal" conference was that the fields working for the health of individuals, families, and communities need to increase their exchange of ideas, information, insight, training, and collaboration at all levels. People in prevention, treatment, 12-step programs, NACoA, community organizations, advocacy groups, educational systems, mental health, child abuse prevention, medicine, government, and all the social services have valuable information, experience, and effort to add to the mix.

Children of alcoholics rarely become "problems" until they begin their own chemical problems

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According to Stephanie Brown, there has been nowhere near enough interdisciplinary work and study among mental health, chemical dependency, and the popular movement for children of alcoholics. "We need a brand new commitment that expresses a willingness to collaborate and cross disciplines," said Brown. "If you're going to work with the addictions you have to be able to take your blinders off and expand your own view. You've got to be able to think in terms of behavioral, cognitive, dynamic issues, developmental issues.

"For prevention it will be essential to study and incorporate concepts from the related fields, incorporate information about all the various kinds of tracks of development, how we get our conception of identity in the family," she said. "I think what we have to do is combine education with what we know about attachment and some of these other concepts."

7. CONTINUE TO WORK ON OUR OWN GROWTH

The ability to talk about health, and the willingness to work hard to promote it, are important qualities for anyone who seeks to help people raised in troubled families. But for children — and adults too, for that matter — no description of health will have anywhere near the impact of seeing it in practice. What good will it do to talk to a child about self-esteem if we're self-deprecating or — even worse — judgmental and critical in our day-to-day interactions with that child? "The most important thing to model to these children is our health," said Moe. "And keep in mind that often we're the first healthy people that they've ever had in their lives."

One danger in any human service field is the temptation to focus all of our energies on other people's needs, and neglect our own. Healthy living takes time and effort, the kind of effort that's very easy to put off "until things calm down." Particularly in the fields related to children and families, both the needs and the temptation to ignore them can exist at high levels. And one of the strongest motivations for helping people relieve or avoid pain can be the memory of experiencing pain, or caring about someone afflicted with it. That memory can be accompanied by extra burdens.

"We are very aware in the children of alcoholics field that people who go into helping fields of various kinds are frequently given what we might call 'cradle-to-grave' training," said Brooks. "When we do surveys of helping professionals — particularly certain ones: social workers, nurses, teachers, and clergy — we find astonishing percentages of children of alcoholics. In some cases, 60-75% of the survey groups are children of alcoholic families.

"Of course, most of the people responding, if they are able to say 'Yes, one of my parents or my grandparents was alcoholic,' on the next question — 'Do you believe that this significantly affected you?' — the answer is 'No.' And if you do personal interviews, what you usually hear is, 'but it really screwed up my sister.'"

Several speakers at the conference

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warned that simply wanting to help present and future generations is not enough. The dedication and conviction that can come out of a troubled childhood do not negate or cure whatever problems that experience instilled. Unless they are addressed on an ongoing basis, those problems can keep people and organizations from working together in consistently healthy ways, and undermine efforts to model and promote health. "Sometimes people who have had this in their background haven't done enough of their own healing and enough of their own work," said Moe. "You simply can't give these kids something that you don't have."

James Dempsey described a program planning process they'd undertaken in his Native American tribe. "The idea was, 'What are we going to do for the children? What are we going to do to break this generational cycle?' And the word from the people was, 'We need

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NACoA State Chapters

National Association for Children of Alcoholics
Margret Dugan, Executive Director
31582 Coast Highway, Suite B
South Laguna, CA 92677
(714) 499-3889

Alabama Association For COA's & Others
Lana Spencer
1008 Fourth Street, N.E.
Birmingham, AL 35215
(205) 853-9779

California Association For COA's
Beth Kotkin
P.O. Box 28087
San Jose, CA 95159
(408) 761-0157

Colorado Association For COA's & Others
Joan Banks
2660 Forest Street
Denver, CO 80207
(303) 333-0340

Connecticut Coalition For COA's
Gloria Merritt
80 Kennelworth Dr. East
Stamford, CT 06902
(203) 348-3006

Delaware Association For COA's
Ken Potts
P.O. Box 4575
Newark, DE 19715
(302) 656-5554

Georgia Association For COA's
Toni Mills
P.O. Box 1574
Tucker, GA 30085
(404) 457-8273

Hawaii Association For COA's
Renee Garvin
974 Maninihoio Street
Honolulu, HI 96825
(808) 396-9032

Illinois Chapter For COA's
Patricia Pape
618 S. West Street
Wheaton, IL 60187
(708) 668-8234

Kentucky Association For COA's
Patti Hard
1517 Nicholasville Rd.
Lexington, KY 40503
(606) 278-1315

Louisiana Association For COA's
Hollyce J. Mason
1035-C Veterans Blvd., Suite 217
Metarie, LA 70055
(504) 455-9700

Massachusetts Association For COA's
Thomas McDonough
55 Pleasant Street
Newburyport, MA 01950
(617) 462-4179

Michigan Association for COA's & Others
Michael Opsommer
P.O. Box 278
Whitmore Lake, MI 48189
(313) 288-6636

New Jersey Association For COA's
Carol St. John
295 Grandview Circle
Ridgewood, NJ 07450
(201) 445-6337

New York St. Coalition For COA Families
Kathleen Ayers
21 Penn Commons
Shirley, NY 11967
(516) 345-5140

North Carolina Association For COA's
Linda P. Miller
3824 Barrett Dr., #222
Raleigh, NC 27609
(919) 783-7733

Ohio Association For COA's
Carol Toth
7566 Wake Robin Drive
Hudson, OH 44236
(216) 434-4141

Pennsylvania Association For COA's
Beverly R. Nagy
2341 Walbert Ave.
Allentown, PA 18104
(215) 434-2431

Rhode Island Association For COA's
Claire Scola
P.O. Box 1923
E. Greenwich, RI 02818
(401) 885-2686

South Carolina Association For COA's
Pete Johnson
814 Kings Bridge Road
Columbia, SC 29210
(803) 772-1872

Texas Association For COA's
Peggy Morton
3905 Birchman Ave.
Fort Worth, TX 76107
(214) 373-4673

Washington Area Association For COA's & Others
Jim Paradiso
6100 Westchester Park Dr.
College Park, MD 20740
(202) 546-5140

Wisconsin Association for COA's
David Arendt
P.O. Box 17065
Whitefish Bay, WI 53217
(414) 332-8322

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help for ourselves first.' And things just happened. First it was the healing for ourselves, second it was the health providers. It was then our leaders — our elders, our spiritual leaders. And then it went into families, and then communities. It was like the picture of a hub, working your way out. It's a beginning for us now. The focus is on the children too, developing healthy models for children to grow to."

Points To Consider In Our Words And Programs

8. THE AMOUNT OF TROUBLE CHILDREN ARE CAUSING FOR ADULTS DOES NOT TELL US HOW TROUBLED THEY ARE

In a world of limited time and money, the temptation is just to identify people with special needs and problems, and design special programs for them. This option has several flaws where the needs of children of chemically dependent families are concerned.

First, there's the danger of reinforcing the children's own sense of shame by "identifying" them. Group and individual counseling programs for children of chemically dependent families can be important and effective if they're done well and carefully. But without safe preparation, only a small percentage of the children who need help will ask for it, or make their needs apparent in other ways. "About 75% of children of alcoholics I've worked with fall into the category of either very approval seeking, very achievement oriented, or very quiet and unobtrusive children," said Brooks. "Only 15% of the kids I've worked with fall into the category of 'problem' children."

Brooks described the results of a study of children of chemically dependent families who had been referred to her organization for counseling. Some, about 25%, had been identified by the referral sources as having "behavioral problems."

"We put them into one batch, and then we put into another batch all the kids who were there just because somebody in their family or somebody in their system believed they might need some help. But in most of those cases, you should know that their families as a whole, and very often their extended societies, told us that these children had no problems and didn't need help.

"When we did sample psychological testing of that whole group, here's what we found. Overall, the children in the 'problem' category tested out much healthier mentally. They showed higher self-esteem, stronger self-preservation instincts, and a clearer sense of who was responsible for what. Interestingly enough, a large portion of that 25% were kids who were initially referred for runaway. They scored the highest in terms of self-esteem, self-preservation, and ability to differentiate responsibility.

"This kind of twisted our heads around a little bit. We began to say, 'You know, what happens in our culture is that we don't pay attention to kids' pain until it causes us pain.' Children of alcoholics rarely become 'problems' until they begin their own chemical problems. And then what do we do? We look at them as chemical dependents."

9. ALL CHILDREN NEED AGE-APPROPRIATE INFORMATION ABOUT CHEMICALLY DEPENDENT FAMILIES

If the classroom or community program will be in most cases the first — and in many cases the only — chance to reach children whose needs are acute, then what's the best way to use this opportunity? The following sections talk about things to be careful of, and things to incorporate, in general-audience programs for children. This section discusses the importance of getting information about chemically dependent families to *all* children.

"If we were only providing services for children from families with alcoholism to those children whose families were in treatment and were taking their children, then we'd be missing 85% of the kids that need our help," said Ruth Davis in a workshop on NACoA's Elementary School Project. "If you're talking to a large group of kids in a school system, and giving these messages, you are reaching the one out of five in that classroom living in a family with alcoholism." Davis mentioned some of the messages NACoA has printed on posters for schools:

- You're not alone.
- It's not your fault.
- Alcoholism is a disease; it's not your parents' fault.
- Alcoholics can and do recover.
- As a child you're a person of worth and deserve getting help.

According to Davis, information about the nature of the disease can go a long way toward alleviating the fear and confusion that children feel, and "helping them to understand what alcoholism is, because often there's not a name for what it is that's going on. And what they're being told it is is something very different from what is really going on, because the entire family's in denial."

The most important thing to model to these children is our health

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Children need to understand that chemically dependent and codependent parents can love their children very much, and still be unable to show it consistently because of their disease. Information can also help children deal with the sense of betrayal they feel when parents contradict or deny things they said or did the night before. "You can do education about blackouts, and explain what blackouts are, and why parents have them," said Ellen Morehouse, also in the Elementary School Project workshop.

"By your painting that picture, the first thing you're doing is breaking that student's isolation. You're letting that student know that you know what it's like, obviously because other people have talked about it. And you're making it a little bit safer for them to talk about." Morehouse cautioned that all of this information needs to be placed in words that will be appreciated and understood at the age level they are reaching. "Too often

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we use techniques that are not age appropriate. We talk in jargon that doesn't make sense for the adolescent, instead of reframing it in a way that makes sense for kids."

Far from being irrelevant to children whose parents are not chemically dependent, "The messages that we're talking about are important things for all children to hear," said Davis. "We know at CASPAR, through some of the research we've done, that children hear the same information and apply it to their lives differently."

Brooks talked about her experience in bringing these types of messages to general audiences of children. She found that children who didn't come from chemically dependent homes really wanted to hear what she had to say, and benefited from it. "If you talk about the pain and sadness and embarrassment of living in a home with chemical dependency, the kids who don't live in those homes also appreciate it," she said. "They feel connected too, because they inevitably have friends who live in those situations. They want to know, 'How do kids deal with that? I have a friend who lives in a home like that. What can I do to help him?'

"And what more powerful way is there to let a child know about the dangers of alcohol and other drug dependency than to talk about the hurt they cause in the lives of other children?"

10. WORDS NEED TO BE SCREENED TO AVOID REINFORCING SHAME

Knowledge, insight, and compassion have been cited as essential qualities in one who seeks to address the problem of family addiction for audiences of children. Just as critical is the ability to screen words, to make sure nothing is said that will reinforce or aggravate the shame that is already a large part of many children's lives. As Brooks put it, "Watch how you refer to people and situations."

In addressing children, "The first step is for us to say, 'Look, there are a lot of kids in this school and the country who have moms and dads who drink too much, or use too much medication, or use too many drugs,'" said Morehouse. "'Let me share with you some of the concerns, and some of the things that go on in some of these families.' Don't label them 'problems.' They're 'concerns.' They're 'issues.' And then you generalize, and you go through the common concerns and issues of kids who live in this kind of family.

"Notice the wording I use. I didn't say, 'Let me tell you about the problems and issues of children of alcoholics.' Because what we get from adolescents is, 'Wait a minute. I said my mom drinks too much. Don't you go calling her an alcoholic.' So use the words that a parent 'drinks too much, uses too much medication, or uses too many drugs.' The last thing you want to do is put a label on the parent, so the child can go home and say, 'Well, mom, I was talking to Mrs. Morehouse today, and she said you were an alcoholic.'"

Another danger exists in prevention programs that take a moralistic approach toward substance abuse in general, said Brooks. "There is a great deal of moral judgment that's coming back into the addictions field, and it's not coming into the treatment field, but into the prevention field," she said. "Children — particularly post-latency-aged children — are very concerned about things legal or illegal, very concerned about good and bad, right and wrong. When you tell a child who comes from a substance-abusing family that driving drunk is morally wrong, and their daddy was drunk when he drove them to school, this sets up a tremendous conflict for the child. What the child concludes is that there's something not good about him, and about his family."

Discussion of illegal drugs also requires care, said Brooks. "We find that most of the children we've been working with have dual-addicted parents. They are not just children of alcoholics anymore. They are children of alcoholics and addicts. And children know about their parents' drug use. A criminalizing approach is shame-based. It may work with the general population, but it doesn't work with the high-risk kids."

In communities of color, it's also important to take cultural family values into account in talking about parents who have alcohol and other drug problems. "There's a greater conflict with loyalty," said Black in her presentation on double duty, the extra burdens that many children bear. "These are people whose population and identity has historically been very subject to attack. Talking about parents in a manner that does not hold them reverent or sacred is often perceived as betrayal."

11. DENIAL AND OTHER SURVIVAL SYSTEMS ARE NECESSARY FOR CHILDREN'S WELL-BEING

Denial that has outlived its usefulness can be a formidable obstacle to adults, blocking out the benefits of recovery. But for children living in chemically dependent households, it can be their only defense — against truths too large to suppress but too dangerous to speak, and levels of pain and anger that they are not yet equipped to process in healthy ways.

"With youngsters, denial takes on a whole different depth and dimension and quality," said Moe. "Denial allows some kids to stay alive. Never take away a child's denial and defenses. Because they go right back into that environment, an environment that you have virtually no control of. And kids break through their denial when they're able, willing, and ready." Ellen Morehouse echoed that advice. "Remember," she said, "the defense mechanism offers psychic protection. And if you remove an adolescent's denial before they're ready to give it

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up, they'll regress into a more primitive defense."

Children of chemically dependent families are also often said to have difficulty trusting. According to Brooks, that difficulty is another important survival system. "A child grows up in a world that tells the child, 'We put you in this family, and this family is going to take care of you. Now the problem is that if you need anything, they won't be there; when they need something, you have to be; and if you ever say you're unhappy with it, you'll be accused of ruining the family. But these are the people that you're going to learn to trust around.'

Denial allows some kids to stay alive. Never take away a child's denial and defenses

"The key, I've learned, is to see his lack of trust — not as proof of his pathology, not as something for you to change, not as something to talk him out of — but to see his lack of trust as something that makes complete sense within the context of his humanity, within the context of where his humanity was born, and most importantly, within the context of the magnificence of his survival."

12. SUPPORT SYSTEMS NEED TO BE IN PLACE

When information about the family disease is presented to general audiences, most children with strong denial systems will filter the words and keep them separate from the realities they are not ready to examine. But what about the children whose denial breaks down under the information? What safety and support systems must be in place before that has a chance to happen?

Suggestions from the conference included safety messages built into all presentations that deal with these issues; training for teachers and counselors before the presentations begin, so that they're ready to provide immediate support for children who need it; and ongoing counseling and mutual-support groups for children of chemically dependent families, engineered so that their participation won't be known to their classmates.

Safety messages can be fairly simple. "We're teaching kids about a concept called 'safe people,'" said Jerry Moe. "Because children of alcoholics — not only little ones, adolescents and adults — are notorious for always picking the wrong people to share things with." A safe person, said Moe, is one who "doesn't laugh, doesn't blab, and isn't always drinking or using. The most empowering thing I could ever do for a child is help them hook up with two safe people in their lives, whether it's a recovering parent, a relative, a coach, a minister, a teacher."

One can also work to make the atmosphere feel safe to children before beginning any presentation that might raise negative feelings, said LaPorte in her workshop on recovery from abuse. One way of doing this would be to let children sit wherever in the room they feel most safe, like near an aisle, or facing the door. Another would be to give children permission to leave the room if things get too uncomfortable; an adult with the appropriate training and skills could be available to help. A third idea LaPorte mentioned would be, before the presentation begins, to ask children to write down the names of some safe people — both in the present situation and when they return to their lives that evening — in case they find a need to talk to anyone about emotions that come up after the presentation is over.

Another good safety measure might be an explanation of denial. Children could learn why many parents who drink too much, use too many drugs, or take too much medication will deny the obvious — and in many cases, get very angry — if they're confronted about it. This could help children make wise choices about what not to say and what not to bring home. Moe cautioned never to let children take anything home — artwork, for example — that might alert chemically dependent parents to the children's growing awareness. "Then a safe space isn't safe any more."

Brooks discussed the need to prepare teachers before information is presented, so that they will be able to respond appropriately to any reactions children might have. "What you really need to do is to have an in-service for teachers before anything is done in school," said Brooks. In some schools she has found that many teachers are hesitant to be approached by children about problems at home. "A lot of times adults feel that, if a child tells them about a problem, that's a mandate for the adults to do something," she said. "But in a lot of cases, nothing can be done, or should be done. So sometimes we work with a few teachers who are willing to talk to kids. Then in our presentations we say, 'If anything comes up for you, you've got four people in this school you can talk to. They don't have the answers, and they can't change

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anything, but they won't talk to your parents.' A lot of times all a child needs is to see that they are safe to say what they're feeling. They don't need counseling. They don't need guidance. All they need is a safe place to talk."

For the children who are ready to begin working on the issues generated in their families, it's important that good programs be available, said Ruth Davis. "I feel very strongly that groups are the ideal way of working with kids," she said. "It's very hard to communicate to a very concrete young child that they are not alone when they are sitting individually talking to an adult. They are indeed alone. And there's tremendous power in children sharing the experience, in helping them learn how to communicate with other children, in helping them learn to support one another. That will translate to some of their other experiences, and I've found that they're less likely to isolate when they're outside school."

The group for children of chemically dependent families should be one of many groups run by the school, said Morehouse. For example, her Student Assistance Services runs groups for seniors, newcomers, children of alcoholics, and substance abusers, and a group called "parents, peers, and partying." "Nobody knows the names of the groups. We don't say, 'The group for CoAs will now meet in room 101.' Everyone just knows they're coming to one of Mrs. Morehouse's groups. The key to doing the groups for CoAs is to make it anonymous, to make it really safe for them so they won't be labeled and they won't be stigmatized."

The groups' benefits are many, said Morehouse. "Who's the best person to tell a CoA what's the best way to cope with the pressures they feel as a CoA and as an adolescent? Other adolescents who have dealt with it. Kids can share solutions and ideas. The group also provides positive peer support for breaking the 'no-talk rule.'"

According to Morehouse, another advantage of the groups is that they increase children's readiness for Alateen and other 12-step programs — important resources that they may need to tap. "For too long school people have been saying, 'Go to Alateen meetings,'" she said. "And think about it: what happens if you're Catholic or Jewish, and the Alateen meeting is at the Presbyterian church at 8:00 at night, and it's ten miles from where you live, and you're only 15? The reality is that most of the kids who are in Alateen have parents who are already in recovery or in one of the other 12-step programs or treatment. But by being in a group in a school, the kids feel more ready and able to take a risk to get to an Alateen meeting."

13. ALL PREVENTION PROGRAMS SHOULD RESPECT THE REALITIES IN WHICH CHILDREN LIVE

Presenting good information about family chemical dependency is an important start. The next challenge will be to make sure *all* of our prevention programs and materials — and the words in which they're presented — work for all of the children who need them. For children who live in chemically dependent families, traditional prevention programs often fall short, said Cathleen Brooks. "They don't take into enough account who the high-risk children really are." Along with the danger that moralistic approaches present (described above in Number 10, "Words need to be screened . . "), some prevention programs describe reality in ways that children of chemically dependent families know are not true in their lives.

These are programs that paint substance abuse as something that exists "out there" among dangerous peers and lurking strangers. Parents are portrayed only as sources of strength and help, with no mention of the possibility that some parents are caught up in the problem, too. "The child or adolescent hearing these kinds of presentations often feels turned off to adults even more than they were before," said Brooks. "They feel that adults truly don't understand what's going on in their lives. This type of program is not only ineffective in working with high-risk children — it's often countereffective.

"This child's understanding of alcohol is so much deeper than what is being presented. 'Yeah, they're talking about alcohol, but they're not talking about it in a way that means anything to me!' I've heard this so often as a reaction from kids I've worked with. They sneer at it." She gave the example of a widely accepted prevention curriculum. In its lesson on "staying safe," it talks about what children should do if they're riding in a car and the driver is drunk. It says, 'Get out of the car and call your parents.' Can't you just feel how these kids are turned off when they hear that? Instead, we need to talk about, 'What do you do when the person who has complete control over you is drunk?'"

A lot of times all a child needs is to see that they are safe to say what they're feeling

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Another concern centers on the need that some programs have for parents who understand and support their children's participation. "We have to start by admitting that the kids we really need to reach have parents who won't come to our programs," said Brooks. "We have to start thinking, 'How can we create a program during school hours so their parents don't have to bring them in for it — so their parents don't even have to know there's a program?'"

14. INFORMATION ABOUT CORE ISSUES CAN HELP STRENGTHEN SELF-ESTEEM

If one of the most damaging — and most dangerous — legacies of growing up in a troubled family is an essential, underlying sense of shame, what can schools and prevention groups do to address that problem? How can we reconstruct and supplement the components of healthy self-worth, and teach them in terms that children and adults will accept and understand?

In Illinois, most prevention programs already place high emphasis

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on building self-esteem and assertiveness skills, in the context of peer leadership, peer resistance, and alternative activity programs. This is an important facet of prevention. But the suggestion here is a type of program that centers on self-worth — on the core elements that are necessary for its development, and the core attitudes that accompany it and allow it to remain strong. It would require a synthesis of the types of concepts touched on earlier in this article in Number 5, "Focus on the core issues." Concepts like healthy boundaries, age-appropriate expectations, acceptance, detachment, direct communication, living in the present, and taking care of oneself (physically, mentally, emotionally, etc.) could be described and modeled for age-graded general audiences of children and adults. Their relationship with healthy self-worth could be woven into the presentations, along with an affirmation that these are skills that can be developed at any age.

For example, a discussion of healthy boundaries might begin with a description of what boundaries are, and examples of how healthy boundaries help in day-to-day functioning. The relationship between healthy boundaries and trust, self-esteem, and taking care of oneself could be explored. Next it could describe the types of problems (reactivity, enmeshment, overcontrol, caretaking, isolation, etc.) that people experience when they haven't learned to clarify and respect their own boundaries. These discussions could be tailored to the appropriate age levels, and illustrated with the types of concrete examples that would make them understandable to young children. For older children, teens, and adults, discussion could also cover the ways in which children form healthy boundaries when families function in healthy ways, and how that formation can be inhibited when parents' troubles are severe, or when parents were not raised with sufficient clarity around their own boundaries. Finally, the relationship among boundary problems and physical, sexual, and substance abuse could be explored.

Speakers at the conference made it clear that, although problems with these types of core elements do not cause chemical dependency, they certainly can make self-destructive and self-defeating choices seem more compelling. They can also make recovery — from childhood trauma and/or later chemical dependency — more difficult to grasp, or even to seek. Many people never even encounter some of these concepts — "boundaries" is a good example — until they reach counseling, treatment, or 12-step recovery programs. Then the burden is much greater, and the work much harder. Why not find ways to present these concepts before problems get to that point? It would by no means replace the recovery process for people whose childhood issues or adult patterns make that process important. But it might increase healthy functioning, and make recovery easier if and when that path is chosen.

Translated into age-appropriate and culturally appropriate terms, this type of information could reach general audiences of parents, children, teens, teachers, and community members. The information could — and no doubt should — be presented separate from information about chemical dependency in the family. That way, it wouldn't be quite as likely to get mixed in with the emotions connected with that issue, and children and adults still in denial wouldn't shut the information out. Besides, these issues are not limited to chemically dependent families. It would be fair to say that many of the pressures facing families can make it difficult — or impossible — to provide all of the types of consistent, healthy guidance that children need. This lifts the blame from the individual families, or even the disease of chemical dependency, and places it squarely on history.

In working with parents, the best approach would be to ask them to think about the information in terms of their own lives — their own childhood experiences and their own development — rather than apply it immediately to the way they raise their children. This approach is less threatening, and unless the healing of their own childhood scars is underway, it will be much more difficult to address the present.

15. IT'S IMPORTANT TO FOCUS ON STRENGTHS, RESOURCES, AND RESILIENCIES

Simply put, children of chemically dependent families are victims of negative messages. These can be small messages — a few harsh words now and then, a look of disapproval, a vote of confidence withheld — or large, loud, deafening, messages. Applied over time, these messages become a main staple of children's self-concept. Logic can't drown them out. Neither can success. Sometimes substances can for a while, but then they get much worse. And against all intentions they get passed on to the next generation of children, until someone has the courage to work on getting well.

One of our most important opportunities is to begin as early as possible to apply positive messages, something that prevention is well prepared to do. Backed up with respect and a willingness to believe in children's potential for health, these messages will have their effect. It's a matter of pointing out strengths; they're already experts on their "weaknesses." "We spend way too much time looking at what's wrong with these kids, and we're not spending enough time looking at the incredible resiliency they possess to make it through," said Moe.

In many cases, the family itself is another important source of strength. Minimizing family problems would be a severe mistake, but it would also be a mistake to discount the love and other resources that exist there despite the troubles. We can take this into account when we talk about

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chemically dependent family issues. And some of the burdens that many children of troubled families develop and carry into adulthood — perfectionism, excessive responsibility, caretaking tendencies, to name a few — are actually strengths taken to excess. The challenge is not to reverse their direction, but to encourage balance.

We spend way too much time looking at what's wrong with these kids...

For many children of chemically dependent families an important step will be learning about 12-step recovery programs. Although the media are beginning to present more current and accurate information about these programs, many children and adults still attach negative preconceptions to them. Unaware of the benefits the programs offer — even to people who are not yet chemically dependent and not currently living with the disease — many children of chemically dependent families put off exploring those options until problems have progressed to high levels of pain. The more that we in prevention are able to understand and accurately describe what goes on in recovery programs, the more we can help remove the mystique and stigma from them in the minds of the children and adults who might need them.

Additional resources of strength, dignity, creativity, and self-esteem lie in another legacy that these children have, that all of us have: the wisdom, values, and traditions of our cultures of origin. "We're all products of people before us, whatever culture we are," said Dempsey in the cultural diversity workshop. "I think today, somehow, in all our cultures we're sort of developing this alcohol culture — this drug culture — because of things that have been lost. For all of us, the importance of where we come from is significant."

"I need to know that I am of African descent," said Jones. "I need to know that I come from a proud and ancient people. *We* need to know that. Whites need to know that. Latinos need to know that. Native Americans need to know that. Little kids need to know that." We can encourage the full use of cultural resources, by studying and owning the positive values of our own cultures of origin, understanding and respecting the values of other cultures, and celebrating the diversity in which we live.

In prevention, this positive focus — on children, adults, families, programs, communities, cultures, and ourselves — may be our best resource in emulating Figueroa's traditional healer, the one who "exemplifies hope." We can keep that focus, through our study of the complexity of family dynamics, and through the words and programs we offer. When hope is grounded — not in denial, but in an honest acknowledgement of both problems and resources — it can be strong enough to counter even the generational momentum of this disease. We can show with our words and our actions that, not only is a child's pain important, but so is that child's hope.

...and we're not spending enough time looking at the incredible resiliency they possess to make it through

Figueroa's description of the healer sounds a little like the way we describe our vision of prevention: "The healer is action-oriented. S/he is knowledgeable, decisive, and actively involved. The healer brings enlightenment. S/he encourages understanding of one's humanity, while instilling hope. S/he models and inspires connectedness to everything. Every one of your actions is somehow affecting someone else.

"A healer brings empowerment. Telling the person who they are. A healer has the ability to help the person recognize their own strengths."

As troubles in life are laid down one by one, they can often be lifted one by one — a few kind words, a look of understanding, a vote of confidence. Figueroa told the old African story of the medicine man called in to heal a sick child. "The medicine man whispered a couple of words in the child's ear, put him down, and said, 'The child will be fine now.'

"An observer said, 'What is this nonsense? A couple of words, and this child is fine?' The healer turned around and said to the man, 'You're a fool! You don't know anything!' The man blushed, and he hunched his shoulders, embarrassed.

"And the healer said to him, 'If a few words could cause such suffering, could not a few words heal the pain?'"

SPEAKERS QUOTED

Claudia Black, Ph.D. Internationally known lecturer and trainer, based in Laguna Beach, California; author of *It Will Never Happen to Me*, an early standard in the Children of Alcoholics field, *My Dad Loves Me, My Dad Has a Disease* (a book of drawings), *Repeat After Me, It's Never Too Late To Have A Happy Childhood*, and (soon to be released) *Double Duty*; founding board member, past president, and current advisory board member of NACoA.

Cathleen Brooks. Founder and President of NEXT STEP, a San Diego, California- and Montana-based national training center for education and consulting in the alcohol and other drug field; primary faculty member of the Suzanne Somers Institute; nationally recognized lecturer and author of *The Secret Everyone Knows*, a book written for young and adult children of chemically dependent families; founding board member and current board president of NACoA.

Stephanie Brown, Ph.D. Director of the Addictions Institute, Menlo Park, California; Research Associate with the Mental Research Institute; nationally recognized consultant and lecturer; author of *Treating the Alcoholic* and *Treating Adult Children of Alcoholics*.

Ruth Davis, Ph.D. Director of the CASPAR Alcohol Education Program, a Somerville, Massachusetts-based training, consultation, and program-development organization; Clinical Instructor in Psychology, Department of Psychiatry, Harvard Medical School; current board member of NACoA.

continued

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healthy visions of the future.

In the United States, alcoholism and its related problems are the fourth most serious national health problem involving 10% of the adult population (U.S. DHHS, 1987). From the *Sixth Special Report to the U.S. Congress on Alcohol and Health* (1987), it is estimated that 18 million persons 18 years old and older experience problems as a result of alcohol use.

In Australia and New Zealand, the statistics are equally as startling. In Australia, it is estimated that 11% of men drink more than 100 ml. of pure alcohol daily (Sargent, 1979). Alcohol is a major factor causing the deaths of over 30,000 Australians. Over one quarter of a million Australians can be classified as alcoholics; more importantly, alcoholism among the young is increasing dramatically (Baume, 1977).

In New Zealand, economic, personal, social, and health care costs of alcoholism are a national concern (Cooke, 1987). Caughey (1987) has argued that New Zealand is a nation in crisis when it comes to the alcohol problem. According to his report, *Sense and Alcohol* (1987), the estimated annual consumption of absolute alcohol in liters in New Zealand has increased by nearly 100% since the Second World War. He estimates that there are 50,000 alcoholics (alcohol dependent) and 100,000 hazardous drinkers. Consequently, the children of approximately 5% of the New Zealand population can be considered at risk for subsequent alcoholism, alcohol related problems, and maladaptive behavior. It is especially alarming to realize that among 14- to 17-year-old New Zealanders, attitudes toward drinking (when contrasted to other variables such as age and sex) display the strongest link with consumption patterns (Stacey and Elvy, 1982).

Alcohol and other drug abuse (AOD) problems affect individuals, families, communities, populations, and countries. AOD problems are often accompanied by negative consequences (e.g., financial distress and under-employment) and chronic family disruption that result in problems among people close to the drinker, as well as problems for the society that must cope with the alcoholic's behavior. Of the total costs to U.S. society, Ashley (1989) states that "An estimate of the economic impact of alcohol abuse and alcoholism in 1983 put the costs to society at almost $177 billion (US DHHS, 1987). Lost employment and reduced productivity accounted for almost $71 billion of the estimated total cost to society. This figure highlights the impact of alcohol-related premature mortality and illness. Direct treatment and health support services cost approximately $15 billion." (Ashley, 1989, pg. 308).

Health problems, drinking related traffic accidents, and negative socioeconomic consequences are the more visible adverse consequences of alcohol abuse. Along with a host of medical problems such as liver cirrhosis, alcoholism is associated with two organic brain diseases, Korsakoff's psychosis and alcoholic dementia. The most consistently observed negative effects for the alcoholic, however, have been found to be the impairment of cognitive functioning, including attention, memory, and information processing.

The risk for these and other types of problems for members of alcoholic families is great. Alcoholism is, indeed, a family disease (Bennett and Wolin, 1990). Alcoholics are more likely than non-alcoholics to have an alcoholic father, mother, sibling, or distant relative. Cotton's 1979 review of 39 data sets on the familial incidence of alcoholism shows that almost one-third of any sample of alcoholics studied have had at least one parent who was reportedly also alcoholic. In her review, alcoholism was found to be specific to families of alcoholics, and other problems — such as depression — did not occur nearly as frequently as alcoholism in these families. Furthermore, alcoholism was more prevalent in male than in female relatives of alcoholics.

What is it like coming from an alcoholic family? It often depends on the age of the child, the relationship with the parent, the severity of the parent's drinking, or the sex of the alcoholic parent. One of the ways in which children of alcohol or other drug abusing parents differ is in their home environment; a disrupted home environment for a child can mean worry, fear, and sometimes abuse. Research has shed some light on the

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James Dempsey. Clinical Coordinator of NEXT STEP; Certified Chemical Dependency Counselor with ten years in the field, and expertise in young children and adolescents, parenting and family problems, and the effects of cultural loss.

Ron Figueroa, M.A., C.A.C. Executive Director of the Rockland Council on Alcoholism in Nyack, New York; former assistant director of Project Rainbow, one of the first treatment programs in the country for children ages 6-18; faculty member of the School of Alcohol Studies, Rutgers University.

Lottie Jones, Ed.D. President and CEO, National Council on Alcoholism and Drug Dependence, Greater Detroit Area, Southfield, Michigan; creator, president and CEO of the BABES Program (Beginning Alcohol and Addictions Basic Education Studies), an award-winning prevention program for children.

Betty LaPorte, C.S.W. Director of Education and Training for the Children at Risk Parent Support Project, a Rockland County, New York-based substance abuse prevention program for children of chemically dependent parents; co-founder and co-director of The Second Step, a consulting firm based in Connecticut and New York.

Jerry Moe, M.A. Director of Children's Services at Sequoia Hospital Alcohol and Drug Recovery Center in Redwood City, California; national lecturer, consultant, and trainer on children of alcoholics; author of *Kids' Power: Healing Games for Children of Alcoholics;* board member of NACoA.

Ellen Morehouse, A.C.S.W. Founder and Director of Student Assistance Services Corporation, Ardsley, New York; co-author of *Children of Alcoholics: Meeting the Needs of the Young COA in the School Setting;* founding board member and current advisory board member of NACoA.

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problems and behaviors that children of alcoholics experience.

Traditionally, two approaches have been used to study the transmission of alcoholism. First, from the genetic perspective, a biologically determined inclination toward becoming alcoholic is considered to be the basic factor in transmission. Secondly, the environmental (or cultural) point of view emphasizes the influence of social or familial values and behaviors regarding alcohol use on the development of alcoholism among the offspring of alcoholics. Today, most alcohol researchers advocate a multifactorial framework where genetic composition serves as a predisposing factor while particular cultural experience constitutes a precipitating factor in the transmission of alcoholism.

Alcohol and other drug abuse problems affect individuals, families, communities, populations, and countries

Four types of studies test the hypothesis of a genetic component in the transmission of familial alcoholism: family, twin, adoption, and half-sibling research (see review by Alterman and Tarter, 1986). In family studies, a consistent pattern of the high prevalence of alcoholism among first degree relatives is reported (Cotton, 1979). Twin studies have shown that monozygotic twins are more often similar to each other than dizygotic twins with respect to being alcoholic or non-alcoholic. It is important to acknowledge that although these studies support the idea of a biological predisposition, they also suggest that family environment may play a critical role in transmission (see reviews by Johnson and Bennett, 1989; Sher, 1987).

Adoption studies carried out in Denmark, Sweden, and Iowa provide the most convincing evidence for genetic influences on transmission (Goodwin et al, 1973; Cloninger et al, 1981). Goodwin and his colleagues (1973) showed a significantly greater influence of biological parents (compared with adoptive parents) in the development of alcoholism among adoptees. In a review of this research, the *Sixth Special Report to the U.S. Congress on Alcohol and Health* (1987) cites the following: "Alcoholism was significantly more prevalent in the adopted sons of alcoholic biological fathers: 22.8% of the sons of alcoholic biological fathers were alcoholic, compared with 14.7% of the sons who did not have an alcoholic biological parent. Alcoholism in the biological mother also was a predisposing factor: 28.1% of the sons of alcoholic biological mothers were alcohol abusers, compared with 14.7% of sons who did not have an alcoholic biological parent" (page 29).

In addition to biological risk, children from alcoholic families may also have increased likelihood of alcoholism and maladaptive behavior due to environmental factors. These children can be considered vulnerable to alcoholism because of the influence of the environmental and behavioral problems associated with alcoholism in their drinking parent. The research on children of alcoholics has spanned across many different behavioral domains which include, but are not limited to, neuropsychology, electrophysiology, personality, self esteem, and depression (see review by Sher, 1987). Most of the research on CoAs has been done in the United States; some has also been done in Europe (Matejcek, 1981). Aside from the exceptional dissertation work of Martin Laurs, who demonstrates an exceptional sensitivity to the problems of children of alcoholics, very little research on CoAs in New Zealand has been established.

The most well documented attempts at studying the effects of alcoholism on development has been the study of the Fetal Alcohol Syndrome (FAS). This syndrome develops in utero as a result of a mother's alcoholic drinking while she is pregnant. The child born with FAS may be characterized by one of four features:

1) Central nervous system dysfunctions (microencephaly, retardation, irritability in infancy, or hyperactivity in childhood);

2) Growth deficiency (smaller than normal, both pre-natally and post-natally in height and weight);

3) Facial appearance (short fissures, thin upper lip, short nose);

4) Variable major and minor anomalies (malformation of the eyes, ears, and mouth).

A disrupted home environment for a child can mean worry, fear, and sometimes abuse

The research on school-aged children of alcoholics has been so broad-based and methodologically diverse that, unfortunately, it has been difficult to characterize children of alcoholics with one typical behavioral profile (Johnson and Rolf, 1990; Russell, Henderson, and Blume, 1985). Generally, research shows that some psychosocial risk factors may increase the likelihood of alcoholism or maladaptive behavior in children of alcoholics. Research on children of alcoholics shows that CoAs have a higher incidence of emotional, behavioral, and developmental disorders when compared to children of non-alcoholics. For example, children of alcoholics have reported more depressive affect than children of non-alcoholics (Rolf et al, 1988). Three types of psychosocial risk factors appear to delineate differences between children of alcoholics and children of non-alcoholics: cognition, personality, and general adaptation (Berkowitz and Perkins, 1988; Clair and Genest, 1987; Johnson and Rolf, 1988). In general, school-aged children of alcoholics show lower levels of cognition and cognitive competence, gender-related personality profiles (males appear to show more antisocial personality characteristics), and poorer adaptability (see reviews by Johnson and Rolf, 1990; Sher, 1987).

The concept of "adult children" of alcoholics (ACoAs) has received wide public recognition and acceptance. An

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adult child of an alcoholic is any adult who was reared by one or two alcoholic parents (Ackerman, 1987). The ACoA concept is traceable to developments begun at the grass roots level in the early 1980s (Brown, in press). The ACoA movement has a flourishing membership and many representative publications, and is represented by several prominent organizations. In the U.S., the Children of Alcoholics Foundation, Inc., and the National Association for Children of Alcoholics are only two of the many growing organizations whose combined memberships reach towards the thousands. In New Zealand, the recently formed New Zealand National Association of Children of Alcoholics affirms the growing power of ACoAs as a legitimate treatment population.

Many ACoAs report histories of childhood abuse which has been left hidden for many years

Much of the presumed loss of childhood for an ACoA centers on the lack of expressive freedom and the inability to experience positive and spontaneous life events. Ackerman (1987) suggests that not all adults raised by alcoholic parents are affected in the same way, nor do all ACoAs have similar outcomes. Among the many potential influences on outcome, Ackerman (1987) identifies gender and age of the parent or child at the time of alcoholic drinking, cultural values, the degree and type of parental alcoholism, and individual differences in the child's stress reaction and perception of the alcoholic's behavior.

In a conference on Adult Children of Alcoholics sponsored by NSAD in May, 1988, approximately 80 male and female participants were surveyed with regard to their family background of alcoholism and other related problems. The following is a sample of the survey questions where the proportion indicated represents an answer of "yes" to these questions:

50%: Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?

47%: Did you ever argue or fight with a parent when he or she was drinking?

55%: Has a parent ever yelled at or hit you or other family members when drinking?

45%: Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?

52%: Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?

During the course of the 1988 conference, it was also revealed that approximately half of the adults had a personal history of sexual abuse as a consequence of their alcoholic parent or other alcoholic relatives' behavior. The experience of the conference participants has been supported by other research studies showing that a history of child sexual abuse is more prevalent among substance abusers (Rohsenhow, Corbett, Devine, 1988).

Many ACoAs report histories of childhood abuse which has been left hidden for many years. Childhood sexual abuse is hidden because many children do not report sexual victimization for fear of adult retaliation, punishment, or even loss of love. If left untreated or unresolved, however, issues from childhood sexual abuse may be a hidden factor underlying other adult behaviors, such as substance abuse or problems in maintaining intimate relationships.

One research project investigated the prevalence of sexual abuse among girls in the care of the Department of Social Welfare in New Zealand. Von Dadleszen (1987) concluded that over two-thirds of the 136 15-and 16-year-olds interviewed had experienced sexual abuse; nearly half reported more than one unrelated experience of abuse. Half of the abuse was perpetrated by family members or relatives, over a third by others known to the girls, and just under a tenth were strangers.

Among the 1988 conference participants, childhood sexual abuse was discovered to be a main component in either the personal problems of the participants or in the problems of their patients. It was thought, especially in an isolated country such as New Zealand, that sexual abuse was much more prevalent than had previously been suspected and that it was furthermore linked to familial alcoholism. Dr. Max Abbott has commented on the prevalence of sexual abuse in New Zealand:

"Dr. Max Abbott confirms that child sexual abuse is a major public health problem in New Zealand. Working as a counsellor with the Mental Health Foundation, he has been staggered to find that up to half of his clients' problems, relating to all aspects of their lives, stem from sexual abuse in childhood" (Briggs, 1986, p. 34).

This theme was again echoed in the 1990 NSAD conference on adult children of alcoholics. The consensus of the 1990 conference was that more research was necessary to understand the prevalence, impact, and prevention of sexual abuse among ACoAs of New Zealand.

Much of the presumed loss of childhood for an ACoA centers on the lack of expressive freedom and the inability to experience positive and spontaneous life events

Prevention of sexual abuse and AOD problems is a relatively new field in the United States — occurring only over the past ten years (Holder, 1989). According to Laurs (1990), prevention of AOD problems in New Zealand is newer still, as it is just now beginning. Lessons from prevention work in the United States can be incorporated into the prevention field in New Zealand without learning them the hard way. The primary lesson to be learned from the U.S. is that prevention programs must be evaluated. Secondly, prevention must include strategies that affect the environment as well as the

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individual's behavior (Holder, 1989).

From the 1990 conference, it was determined that it was time for New Zealand to invest in tangible ways in the vision of Sir Charles Burns. These tangible ways can include: epidemiological surveys of alcoholism, studies of family transmission, treatment, and solid programs for the prevention of sexual abuse. The study of children of alcoholics can provide information helpful for understanding how alcoholism develops. Through understanding children of alcoholics, we can understand who would be responsive to preventive intervention or treatment and help develop educational and prevention programs.

With the formation of the New Zealand National Association for Children of Alcoholics, children of alcoholics in New Zealand have raised up their hands to be counted. Like a train delivering silver packages, national organizations are formed to go back to the mountains to give the help, support, and understanding to the children of our future so that they also get everything they need.

Dr. Jeannette L. Johnson, Ph.D. is a developmental psychologist with over 17 years experience working with children in educational, applied, and research settings. The past ten years she has focused on children from high-risk environments, especially children from substance abusing families. Currently, Dr. Johnson is a Research Psychologist and Project Officer with the Community Research Branch at the National Institute on Drug Abuse. She is actively involved in community research designed to identify, prevent, and treat health risking behaviors related to substance abuse and the transmission of HIV/AIDS.

Dr. Johnson served as the Project Director for the Panel on High Risk Youth at the National Academy of Sciences and the National Research Council. Her last ten years of research include work with children of addicts at NIDA, and children of alcoholics at the National Institute on Alcohol Abuse. She lectures extensively on young and adult children of alcoholics throughout the country, as well as in Europe and the South Pacific. Dr. Johnson is closely affiliated with the National Society for Alcohol and Drug Dependence in New Zealand and the Patron for the New Zealand Association for Children of Alcoholics.

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FEATURE

Children of Alcoholics: Are They Different?

Editor's Note: Reprinted from *Alcohol Alert*, a publication of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which provides timely information on alcohol research and treatment to health professionals and other interested people. This information has been reprinted from the ninth in the series.

An estimated 6.6 million children under the age of 18 years live in households with at least one alcoholic parent[1]. Current research findings suggest that these children are at risk for a range of cognitive, emotional, and behavioral problems. In addition, genetic studies indicate that alcoholism tends to run in families and that a genetic vulnerability for alcoholism exists[2,3,4]. Yet, some investigators also report that many children from alcoholic homes develop neither psychopathology nor alcoholism. This *Alcohol Alert* focuses on three major research questions concerning children of alcoholics (CoAs): 1) What contributes to resilience in some CoAs; 2) Do CoAs differ from children of nonalcoholics (nonCoAs); and 3) Are the differences specifically related to parental alcoholism, or are they similar to characteristics observed in children whose parents have other illnesses?

Before summarizing the research findings on these questions, it should be said that many studies of CoAs have been plagued by methodological issues. For example, the composition of the sample chosen for a study can affect the study results significantly. Yet, many CoA studies use a biased sample selection of children in treatment or in trouble. In addition, studies often are conducted without the benefit of matched control groups. The absence of control groups makes it difficult to generalize results from treatment samples to nontreatment populations. Children of various ages and developmental stages frequently are grouped in one sample, and the developmental differences within the group are ignored. Another problem is that because few longitudinal studies have been performed, it is difficult to know whether the observed problems are impairments or are developmental delays. In addition, the effect of such factors as marital conflict and the severity of parental drinking on the development of problems should be considered. All of these limitations can affect the outcome of the study. The studies cited below are not free of these methodological problems, but they are the best that we have.

These children shared characteristics that contributed to their success... a caring attitude, a desire to achieve, and a belief in self-help

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While research findings suggest that some children suffer negative consequences due to parental alcoholism, a larger proportion of CoAs function well and do not develop serious problems. In a longitudinal study of CoAs born on the island of Kauai, Werner[5] reported that, although 41% of the children developed serious coping problems by 18 years of age, 59% did not develop problems. These resilient children shared several characteristics that contributed to their success, including the ability to obtain positive attention from other people, adequate communication skills, average intelligence, a caring attitude, a desire to achieve, and a belief in self-help.

Studies comparing CoAs and non-CoAs have suggested that, although the two groups differ in a variety of psychosocial areas, differences in cognitive performance are observed most frequently. Cognitive function in CoAs has been examined by many researchers because it is an important element needed for adaptation at all stages of development; it can be measured uniformly across developmental stages; and it is often associated with the symptoms of alcoholism. Ervin and her colleagues[6] found that Full IQ, performance (a measure of abstract and conceptual reasoning), and verbal scores were lower among a sample of children raised by alcoholic fathers than among children raised by nonalcoholic fathers. Gabrielli and Mednick[7] reported similar results for verbal and Full IQ tests, but not for performance tests. In a study comparing CoAs and nonCoAs whose families were educated and whose parents lived in the home, Bennett and colleagues[8] found that children from alcoholic families had lower IQ, arithmetic, reading, and verbal scores. Despite the lower scores, however, CoAs performed within normal ranges for intelligence tests in each of these studies.

It is important to note that cognitive competence can vary with the instrument used to measure performance as well as with the individual who is evaluating function. Johnson and Rolf[9] compared the academic abilities and cognitive function of CoAs and nonCoAs from nondisadvantaged backgrounds and found no differences between the groups. The investigators noted, however, that the children with alcoholic parents underestimated their own competence. In addition, the mothers of CoAs underrated their children's abilities. The mothers' and children's perceptions of abilities may affect the children's motivation, self-esteem, and future performance.

School-aged children of alcoholic parents often have academic problems. Academic performance may be a better measure than IQ of the effect of living with an alcoholic parent. School records indicate that CoAs experience such academic difficulties as repeating grades, failing to graduate from high

Children of Alcoholics: Are They Different?

A Commentary by NIAAA Director Enoch Gordis, M.D.

The Children of Alcoholics (CoA) movement follows in the rich tradition of many popular movements that have focused public and professional attention on the problems of a vulnerable group. This movement has provided valuable information on the social and psychological problems experienced by many CoAs, based on the observations of counselors, clinicians, school personnel, and others. These observations offer scientists an important starting point as they carefully design studies that seek to define the factors that may increase risk and the factors that may protect CoAs from negative consequences.

In considering CoAs, it is important to remember that, although there is a genetic component to the vulnerability to alcoholism, CoA issues are not related primarily to alcoholism itself but to the social and psychological dysfunction that may result from growing up in an alcoholic home.

Selection bias and specificity are two important research issues. Selection bias means that conclusions based on clinical samples are likely to overestimate the extent of the problems, because only the most troubled come for treatment. The question of specificity is this: are the problems described in CoAs specific for parental alcoholism, or do they occur as often in other dysfunctional families? If the latter is true, then alcohol-specific mechanisms may not account for the problems in CoAs. Further, if all children from dysfunctional homes are at equal risk, then all are entitled to the benefits of any public policy designed to help children from troubled homes.

Children of Alcoholics: Are They Different? *continued*

school, and requiring referrals to school psychologists[10•11]. Although cognitive deficits in CoAs may account, in part, for their poor academic performance, motivational difficulties or the stress of the home environment also may contribute to their problems in school.

Studies comparing CoAs with non-CoAs also have found that parental alcoholism is linked to a number of psychological disorders in children. Divorce, parental anxiety or affective disorders, or undesirable changes in the family or in life situations can add to the negative effect of parental alcoholism on children's emotional functioning[12•13].

The results of several studies have shown that children from alcoholic families report higher levels of depression and anxiety and exhibit more symptoms of generalized stress (i.e., low self-esteem) than do children from nonalcoholic families[12•13•14•15]. In addition, CoAs often express a feeling of lack of control over their environment. A recent study by Rolf and colleagues[16] noted that CoAs show more depressive affect than nonCoAs and that their self-reports of depression are measured more frequently on the extreme end of the scale.

Moos and Billings[13] found that the emotional stress of parental drinking on children lessens when parents stop drinking. These investigators assessed emotional problems in children from families of relapsed alcoholics, children from families with a recovering parent, and children from families with no alcohol problem. Although the children of relapsed alcoholics reported higher levels of anxiety and depression than children from the homes with no alcohol problem, emotional functioning was similar among the children of recovering and normal parents.

Finally, children from homes with alcoholic parents often demonstrate behavioral problems. Study findings suggest that these children exhibit such problems as lying, stealing, fighting, truancy, and school behavior problems, and they often are diagnosed as having conduct disorders[17]. Teachers have rated CoAs as significantly more overactive and impulsive than nonCoAs[11•18]. CoAs also appear to be at greater risk for delinquency and school truancy[12•19•20]. Several investigators have reported an association between the incidence of diagnosed conduct disorders and parental alcohol abuse[21•22•23]. However, other problems associated with alcoholism (e.g., depression among the alcoholic parents and divorce) also may contribute to conduct problems and disorders among CoAs.

The alcoholic family's home environment and the manner in which family members interact may contribute to the risk for the problems observed among CoAs.

Although alcoholic families are a heterogeneous group, some common characteristics have been identified. Families of alcoholics have lower levels of family cohesion, expressiveness, independence, and intellectual orientation and higher levels of conflict compared with nonalcoholic families[13•24•25•26]. Some characteristics, however, are not specific to alcoholic families: impaired problem-solving ability and hostile communication are observed both in alcoholic families and in families with problems other than alcohol[27]. Moreover, the characteristics of families with recovering alcoholic members and of families with no alcoholic members do not differ significantly, suggesting that a parent's continued drinking may be responsible for the disruption of family life in an alcoholic home[13].

The family environment also may affect transmission of alcoholism to CoAs. Children with alcoholic parents are less likely to become alcoholics as adults when their parents consistently set and follow through on plans and

continued

Children of Alcoholics: Are They Different? *continued*

maintain such rituals as holidays and regular mealtimes[28].

Interestingly, the problems of CoAs may not be specific to this population. In a review of research on children whose mothers were schizophrenic, Garmezy[29] reported that, like CoAs, these children had cognitive deficits. In particular, they had a limited ability to maintain attention and to perceive relevant stimuli. Children at high risk for schizophrenia revealed a more negative self-image. The family environment also may influence the risk for schizophrenia; children of schizophrenic parents — whose home environment is turbulent — have an increased risk for developing schizophrenia.

Research on CoAs is still in its infancy. Many studies suggest that a variety of differences exist between children of alcoholics and children of nonalcoholics and these differences occur at all ages. However, because of the limitations of the methodology and the inadequate number of comprehensive studies, research findings cannot be generalized to all children who grow up with alcoholic parents.

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To Roy Johnston, a Founder and Past-President of the National Society on Alcoholism and Drug Dependence, New Zealand, for sharing a global enthusiasm for our work in prevention.

National Coalition's Campaign Theme

"It's A Fact. Alcoholism Tends To Run In Families. Be Aware Of The Risks."

In August, 1989, the federal Office for Substance Abuse Prevention (OSAP) asked the National Association for Children of Alcoholics (NACoA) to invite representatives of several national organizations to meet. These groups included a broad spectrum of experience and concerns about alcoholism in families and about children in these families as a group at high-risk for future problems, including the disease of alcoholism. The meeting considered the possibility of launching a national public education effort about CoAs.

The coalition set December 1, 1990 as the official release date for Phase One of its public education package

Participants agreed that some significant facts about the experiences of CoAs have been established, that resources for CoAs and those interested in helping them now exist, and that the general public is ignorant of the subject. Without a large government budget to undertake public education about CoAs, it was agreed that the groups represented either already had, or might easily develop, basic elements for a public education campaign package. OSAP offered support to collect, duplicate and disseminate these materials and to play a facilitating role.

A second meeting of the group in October, 1989, led to the decision to adopt the name National Coalition for COA Education and to commit to, tasks in preparation for the proposed effort. One early assignment was a research and review of the CoA literature. From this, a fact sheet and other publications could be developed, providing state-of-the-art information on the subject and giving the coalition a set of agreed-upon statements about CoAs.

The coalition met in January, 1990, and again at NACoA's annual convention in August, 1990, at which time an Executive Committee was formed. This meeting also reviewed and revised the fact sheet draft and related materials. Rough cuts of television public service announcements produced for the coalition by ABC and CBS were critiqued and a theme was chosen: "It's a fact. Alcoholism tends to run in families. Be aware of the risks." Finally, the coalition set December 1, 1990, as the official release date for Phase One of its public education package.

The National Coalition for COA Education is made up of influential stakeholders, national opinion leaders, and gatekeepers and constituencies. Its general goal is to develop a communications-centered program to raise awareness of the risks associated with being a child of alcoholic parents, of strategies for increasing resiliency among such children, and of available resources about CoAs. The coalition's current members are:

- Children of Alcoholics Foundation
- Entertainment Industries Council
- National Association for Children of Alcoholics
- National Association for Native

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General Themes And Approaches For Communicating To Children Of Alcoholics And Other Drug Abusers

1. Appeal to the adolescent need for independence.
2. Appeal to peer approval.
3. Confront denial and the invulnerability syndrome.
4. Relabel delinquent behavior.
5. Substitute other healthier behaviors as rites of passage.
6. Tie health as contributing to machismo.
7. Appeal to sexual image formation.
8. Combat the sense of fatalism and external locus of control.
9. Provide positive alternatives.
10. Channel aggression to less harmful behaviors.
11. Perceptions of youth about media and messages may vary from those of adults.
12. Multiple media approaches appear to be popular for reaching teen audiences.
13. The public is sensitive about health-related information aimed at adolescents.
14. There appear to be few good models for communicating health information to high-risk youth.
15. Personal relationships are important in communicating with high-risk youth.
16. Culture and language are important.
17. Communications must address barriers to specific high-risk populations.

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Creating Change for Healthier Youth: Strategies for Living with Alcoholism

NACoA Photo

By Nancy Phillips, MS.Ed., C.A.C.
Manager of Youth InTouch System

Author's Note: *This article is written to youth in the pre-teen to mid-teen years. Please share it with the peer leaders and youth you care about.*

When I was asked to write an article on children of alcoholics (CoA) for this issue of *Prevention Forum,* my response was a quick "sure." Reflecting upon my commitment, I thought about my reader audience and who I really had a message for. It became clear to me that as Youth InTouch Manager, my role is to address you, the youth, and be an advocate for environments that value young people, promote healthy lifestyles, and provide positive role models. All too often for children in homes where there is a drinking problem or alcoholism, a safe environment and healthy role models are limited or non-existent. For young people living in a home where alcohol creates problems, a strong self-concept is difficult to maintain. To grow up healthy and feeling "okay" is tough in this situation. However, there are things young people can do to feel better — no matter what is going on at home.

I want to share with you a story of a girl I knew. As she grew up, her father developed alcoholism. Men are not the only population with alcoholism. Women can develop the same alcohol problems and the effects are similar for the family. However, this family had a father that drank too much. In her younger years, she remembers her parents laughing together, planning together, and life was safe. Family arguments and problems had quiet solutions. But slowly this ended. It happened so gradually that she could not tell you when her life changed. But it did. The arguments became more frequent, the voices louder, and the laughter stopped. Anger and crying took over. Slowly fear and doubt set in.

All too often for children in homes where there is a drinking problem or alcoholism, a safe environment and healthy role models are limited or non-existent

She began to feel alone — nobody else had a family like this. She knew this must be true. She saw her friends' caring parents. They didn't argue about drinking, money, whether the house was clean, or how the food was cooked. They kept promises and had fun together. Arguments did not end in yelling and days of silence. The belief that she was "the only one" living this way caused her to think maybe there was something wrong with her. Maybe she was the cause of this "different" family. Her friends quit coming to the house. She never knew what to expect. One day things would be quiet, and the next, her father would embarrass her with his drinking behavior. It was easier not to have close friends or to go someplace else.

Over the years, her home became more and more confusing. Her father could be so loving one moment and, in a matter of minutes, yelling and blaming her for everything wrong. She was not smart enough, not pretty enough, popular enough, talented enough, etc. If it wasn't her fault, then he blamed her mother. She began to believe she was not "good enough" and no matter what she did — more was always expected. The crazy part was that she believed and

continued

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Creating Change for Healthier Youth *continued*

knew her father loved her and she loved him. This love caused guilt. How could she love someone who caused so much trouble, so much embarrassment, so much anger? Over time, she learned that her mother didn't want to discuss the obvious problem. (Maybe she was the only one who saw the "problem?") She learned that promises were usually broken or forgotten and it became much easier not to feel anything or expect anything.

Thus, my friend learned the three unwritten rules of families that alcoholism affects. The rules of "Don't talk" (so no one else will know our secret), "Don't trust" (because promises are usually broken), and "Don't feel" (then you can survive and there is less pain). These rules appear to be common for Children of Alcoholics, even though each family situation is different.

My friend learned the three unwritten rules of families that alcoholism affects... "Don't talk" (so no one else will know our secret), "Don't trust" (because promises are usually broken), and "Don't feel" (then you can survive and there is less pain)

During the teen years, her parents separated, and eventually divorced. This often happens in families where there is alcoholism. This stopped the arguments at home, but she was still responding to the rules she learned in that home. She grew into adulthood living by the "rules" of the alcoholic family — rules that keep people from developing happy, healthy adult relationships. She grew up a product of her family, using the skills and beliefs given to her at home, not knowing there were other ways to live, not knowing her father's alcoholism was *not* her fault.

A number of years have passed. This girl is an adult with her own family. She now knows about alcoholism. She recognizes how it affected her life and her relationships. With the help of caring friends and professional assistance, she learned to shatter the boundaries created by these rules of the alcoholic family. Now she talks about issues, trusts her friends and her ability to have healthy relationships, and trusts her feelings to surface and be dealt with in a positive way.

In the past years, we have learned a great deal about families and the impact alcoholism has on the members. We have also learned how to assist children from stressed families create happier and healthier lives whether the alcoholic quits drinking or not. The National Association for Children of Alcoholics (NACoA) tells us that there are over seven million young people under 18 at home with at least one alcoholic parent. There are another 21 million adults over 18 who were raised by an alcoholic, like my friend. Many of these adults did not have the support now available to young people. Some never recognized the stresses created by this situation. If you or someone you know suspects alcoholism in their family, don't wait until adulthood to get help. There are strategies available for change now. One of the first steps is to recognize that when young people make it to this point, they should celebrate the survival strategies they have learned on their own and refine them to positive uses. Secondly, learning and understanding about alcoholism is the most important factor. Accepting alcoholism as a disease and understanding the actual chemical reaction to alcohol that takes place for most alcoholic drinkers is vital to releasing the guilt and anger and realizing no one is to blame.

There *are* resources available to young people who allow this understanding to develop. An excellent book to assist in gaining this understanding is *Coping With An Alcoholic Parent* by Kay Marie Porterfield. This book explains, in clear terms, the chemical changes in the brain of a person experiencing alcoholism, and helps promote understanding of the disease concept of alcoholism. Another resource for learning about alcoholism and strategies for creating a better life for yourself and others is the Prevention Resource Center (PRC) library. The PRC library has material written to and for youth (see reading list below). Thirdly, learn about local resources in the community. Through help lines, local Alcoholics Anonymous self-help groups, local community substance abuse treatment centers, and by talking with the school counselor or drug/alcohol coordinator, any youth can obtain resources for him/herself and his/her peers.

Accepting alcoholism as a disease and understanding the actual chemical reaction to alcohol that takes place for most alcoholic drinkers is vital to releasing the guilt and anger and realizing no one is to blame

One last resource of note... in the effort to support and advocate for youth ownership for creating change in school and community, PRC and the Youth InTouch system are offering a training throughout Illinois in January, 1991. This two-day training is designed for teams of adults and/or youth to learn how to deliver *Baseline I: Introduction to Substance Abuse and Prevention for Youth* trainings in their own communities. The Baseline model allows participants to begin to understand the disease concept of substance abuse, how it affects the lives of family members, strategies for dealing with the stress, and how to create a healthy lifestyle. It also offers basic prevention planning for youth involvement.

Along with the model content,

continued

Creating Change for Healthier Youth *continued*

participants will:

- Examine the use of audio-visuals to provide information and generate discussion;
- Investigate ways of creating a safe climate that will encourage participation in the delicate topic areas related to alcoholism and the chemically dependent family;
- Identify and adapt to adolescent learning styles;
- Demonstrate ways of addressing a variety of learning modalities in a training presentation;
- Examine a variety of group facilitation techniques;
- Determine various equipment and logistical needs.

For information about the training, contact the Training Registrar, 800/252-8951 (in Illinois) or 217/525-3456.

Awareness of the difference youth can make for self or someone else by using resources available and sharing them with people in the community creates a healthier environment and healthier youth.

RECOMMENDED READING

Coping With An Alcoholic Parent. Porterfield, Kay Marie. Perrin Thomas W. Inc., Rutherford, NJ, 1985, 135 pages.

Different Like Me: A Book for Teens Who Worry About Their Parents' Use of Alcohol/Drugs. Leite, Evelyn, et al. Johnson Institute, Minneapolis, MN, 1987, 111 pages.

An Elephant In The Living Room: The Children's Book. Hastings, Jill M., et al. 1984.

Living With A Parent Who Drinks Too Much. Seixas, Judith. Greenwillow Books, New York, NY, 1979, 117 pages.

My Dad Loves Me, My Dad Has A Disease. Black, Claudia. 1979, 85 pages.

Pablito's Secret/El Secreto De Pablito. Figuero, Ronny. National Association For Children, South Laguna, CA, 1984, 31 pages.

The Secret Everyone Knows. Brooks, Cathleen. Kroc Foundation, 1981, 40 pages.

When Your Parents Drink Too Much: A Book For Teenagers. Ryerrson, Eric. Facts On File Inc., New York, NY, 1985, 126 pages.

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Audiovisual Review

By Pat L. Barnard, Library Associate
Prevention Resource Center
Springfield, Illinois

A Letter To Dad
½" VHS, adult audience, 60 minutes. Purchase from: Gerald T. Rogers Production, 5215 Orchard Road, Skokie, IL 60077. $575.

This video is a drama about Megan Riley, a divorced mother of two teenagers, who finally confronts the damaging effects of growing up in a dysfunctional family. Megan struggles with a life filled with loneliness and despair. Returning to the small town of her childhood for a funeral, Megan encounters the trauma of growing up with an unpredictable, violent, alcoholic father and a codependent mother. With help and understanding from her therapist and a support group, Megan begins to understand the lasting effects of the messages she received as a child: "don't talk," "don't trust," "don't feel." She learns to grieve the loss of a childhood absent of love and nurturing, resolve the conflict with her parents, and finally, begins building a healthy, fulfilling life.

Drinking Parents
Two ½" VHS, junior-senior high audience, 30 minutes each. Purchase from: MTI, 108 Wilmot, Deerfield, IL 60015. $99.

A set of two videos focusing on the 20 million young people living in homes with alcoholic parents who are often subjected to violence, abuse, and neglect. The special problems of these children are brought to light in this video. Victimized young people and their parents give case history accounts of how they have coped. Also featured are members of Alateen, an organization to help kids survive in alcoholic homes.

Scared, Sad and Mad
½" VHS, primary grades, 19 minutes. Purchase from: MTI, 108 Wilmot, Deerfield, IL 60015. $380.

The effects the actions of an alcoholic parent can have on children can be subtle yet devastating. This video uses puppetry and animation along with live action to teach young children that it is not their fault, that alcoholism is a disease, and that hiding a problem won't make it go away or get better.

Tell Someone
½" VHS, grades 5-high school, 30 minutes. Purchase from: Health Edco, P.O. Box 21207, Waco, TX 76702. $89.95.

This is a 4-minute music video, targeted to children grades 5 through high school, showing the difficulties faced by children of alcoholics in five homes with different ethnic and socio-economic backgrounds. Affected children are urged to find a trustworthy adult to confide in.

All audiovisuals reviewed in *Prevention Forum* are available to Illinois residents for a three-day loan period from the Prevention Resource Center Library.

Clearinghouse Review

By Carolyn Murphy, Library Associate
Prevention Resource Center
Springfield, Illinois

Children of Alcoholics: The Truth Behind Hard Love
3-fold pamphlet. Wisconsin Association for Children of Alcoholics and the Wisconsin Clearinghouse, P.O. Box 1468, Madison, WI 53701. (608) 263-2797.

This pamphlet describes the common characteristics of children of alcoholics and explores the problems and issues that they face. Recovery is discussed and a list of additional resources is provided.

If a Child From an Alcoholic Home Comes to You
1-sided flyer. National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852. (800) 729-6686.

This information sheet, designed for adults who work with children, outlines some helpful do's and don't's for assisting a child who asks for help.

Questions and Answers About Alcohol Problems and What Should You Do?
2-sided flyer. National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852. (800) 729-6686.

Questions and Answers About Alcohol Problems answers questions that kids ask about alcoholism and how to live with an alcoholic.

What Should You Do?, also for young people, offers suggestions to those who live with or know someone with alcohol problems. Talking about feelings and remembering how to have fun is encouraged.

All Clearinghouse materials are available free of charge to Illinois residents.

Resource Review

By Mary O'Brien, Library Associate
Prevention Resource Center
Springfield, Illinois

Coming Home
Peggy King Anderson, 1988, Glen Abbey Books, Seattle, WA. $7.95.

Coming Home is a story written for children and adult children of alcoholics. Through the story's characters, Brian and Jenny, a child or adult may explore their feelings of pain associated with growing up in an alcoholic home.

Different Like Me: A Book For Teens Who Worry About Their Parents' Use of Alcohol/Drugs
Evelyn Leite and Pamela Espeland, 1987, Johnson Institute, Minneapolis, MN. $6.95.

Different Like Me is a book about what it's like to live with parents who abuse alcohol or other drugs. Teenagers learn they are not alone and that it's not their fault if their parents use alcohol and drugs. The book explains the disease called chemical dependency, what it is, and what it does. It also tells teenagers what they need to know to stop feeling "different" and start feeling good.

continued

LIBRARY REVIEWS

Resource Review *continued*

Coping Within The Alcoholic Family
Joseph F. Perez, 1986, Accelerated Development Inc., Muncie, IN. $14.95.

The point of view of this book is that each family has its own personality. Like its individual members, the family personality is dynamic, constantly changing, constantly growing. A family which is not dynamic but static, regresses and becomes sick. The alcoholic family is static. This book will explain how crossed identifications between and among family members too often pulls the non-drinking members into the dynamics of the alcoholic. The reader will come to see how the members' perception and way of relating become alcoholic and how their view of reality and their judgments become impaired. *Coping Within The Alcoholic Family* uses case studies throughout to emphasize its points.

Counseling Activities For Children Of Alcoholics
Apalachee Community Mental Health Services, Inc., 1983, Apalachee Community Mental Health Services, Inc., Tallahassee, FL. $12.

This manual is for guidance counselors who are interested in a specific framework for counseling children of alcoholics in the school setting in grades K-12. The manual is divided into two sections. The first section deals with background information about alcoholism. The second section contains lessons and activities for each of the counseling sessions. The content of many of the sessions is not exclusive to working with children of alcoholics — activities may be used directly or adapted for use with general audiences or specific populations such as divorce adjustment groups.

Another Chance: Hope And Health For The Alcoholic Family, Second Edition
Sharon Wegscheider-Cruse, 1989, Science and Behavior Books, Mountain View, CA.

Another Chance provides an understanding about the dynamics of the chemically dependent family and describes the feelings, behavior, and interactions observed in chemically dependent families. This book is a help to counselors in understanding the confusing behavior that expresses the isolation, low self-worth, and stagnation of the chemically dependent families. It helps counselors guide family members to rediscover their strengths to face the problems of addiction and heal relationships within the family system.

Hope: New Choices And Recovery Strategies For Adult Children Of Alcoholics
Emily Marlin, 1987, Harper and Row Publishers, New York, NY. $15.95.

This book provides hope and specific strategies for change to all adult children of alcoholics. Part one of *Hope* leads the reader to re-examine the past in order to better understand the effects of alcoholism on his/her life. Part two explores the major tasks of recovery and new tools for self-healing. Part three shows how one can further his/her growth by rebuilding relationships with parents and siblings, and by learning from the challenge of parenting.

Other CoA and ACoA materials in the PRC Library:

Breaking the Cycle of Addiction by Patricia A. O'Gorman, et al.

Broken Bottles, Broken Dreams by Charles Duetsch.

Children of Alcoholics by Robert Ackerman.

Grandchildren of Alcoholics by Ann W. Smith.

My Dad Loves Me, My Dad Has A Disease by Claudia Black.

Potato Chips for Breakfast by Cynthia G. Scales.

Struggle For... Intimacy by Janet Geringer Woititz.

Working With Children of Alcoholics by Bryan E. Robinson.

All resource materials reviewed in *Prevention Forum* are available to Illinois residents for a two-week loan period from the Prevention Resource Center Library, (217) 525-3456 or (800) 252-8951 in Illinois.

It's A Fact. Be Aware Of The Risks. *continued*

American Children of Alcoholics
- National Association for Perinatal Addiction Research and Education
- National Black Alcoholism Council
- National Committee for Prevention of Child Abuse
- National Council on Alcoholism and Drug Dependence
- National Institute on Drug Abuse/ADAMHA/DHHS
- National Prevention Network
- Office for Substance Abuse Prevention/ADAMHA/DHHS
- Suzanne Somers Institute
- U.S. Department of Education

Inquiries about the coalition's work from communications, prevention/education, or health professionals and from alcoholism/other drug organizations can be made to George Marcelle, Communications Director, OSAP, c/o NACoA, 31582 Coast Highway, Suite B, South Laguna, CA 92677; 714/499-0430; FAX 714/499-0128.

The *Prevention Express*, Youth InTouch newspaper, published by the Prevention Resource Center, is now available for subscription, free of charge. This newspaper includes articles written by and for youth in the pre-teen to teen years. Anyone interested in receiving the newspaper or in contributing articles for publication should contact:

Barbara Allen
Prevention Express Editor
Prevention Resource Center
822 South College
Springfield, IL 62704

FEATURE

On-Line With PRCBBS

Prevention Resource Center announces a new free Bulletin Board Service (BBS) available to individuals and organizations in the prevention field. The PRCBBS will have articles, newsletters, reports, training schedules, lists of prevention resources, and message areas where users can leave messages and seek or share information on prevention, ideas, and resources. Selected items from the RADAR forum on CompuServe will be posted on PRCBBS for users to access. Files (articles, newsletters, reports, etc.) will be available for users to Download (copy to YOUR computer).

You can call PRCBBS with ANY computer or terminal, and a modem (a device that connects a computer to a telephone), and communication software such as Procomm, Telix, Crosstalk, etc. PRCBBS supports 300, 1200, or 2400 baud modems and will automatically adjust to YOUR speed. Use the highest speed your modem will support.

To get technical, set your communication (terminal) software for N 8 1. This means: No parity, 8 bits, 1 Stop bit. The PRCBBS will support a variety of Upload and Download protocols, including Xmodem and Zmodem. If your communications software supports Zmodem, we suggest you use that, as it's fast and reliable. The phone number is (217) 525-3469 in Springfield, Illinois. This is a 24 hour, 7 day BBS. There are actually four phone lines, allowing four users to connect at the same time.

The PRCBBS will have articles, newsletters, reports, training schedules, lists of prevention resources, and message areas

Give us a call. Once connected, answer the prompts to Register. The trickiest question is "How many columns wide is your screen?" (IBM compatibles are 80 columns.) When in doubt, answer 80, and change it later if necessary.

Callers are allowed 60 minutes on-line each day. As an Unregistered user, you may not Upload files (to the BBS) or Download files (from the BBS) or post E-Mail or messages to anyone but the SYSOP (SYStem OPerator). When your Registration is validated by the SYSOP, all these options are available.

After Registering and looking around, the final step is to use Option E to LEAVE THE SYSOP an E-MAIL MESSAGE saying you wish to be a fully Registered user. If you skip that step, the SYSOP will NOT know that you wish to be a Registered user. Your Registration should be validated in several days.

Our goal is to build an on-line library of resources, materials, and files by January 1, 1991. Computer/on-line phone communication is the wave of the future. Learn how to participate now by calling the Prevention Resource Center Bulletin Board Service. This IS a place for beginners. Give it your best try, and leave a message on the MAIN (or any other) Conference when you get stuck. Tell us what you need, and how the PRCBBS can best serve you. Call today!

Children of Alcoholics Facts and Figures

1. There is strong, scientific evidence that alcoholism tends to run in families.

· Alcoholics are more likely than non-alcoholics to have an alcoholic father, mother, sibling, or other relative. In addition, children of alcoholics (CoAs) are more likely than non-CoAs to marry into families in which alcoholism is prevalent.

· In research studies, almost one-third of any sample of alcoholics has at least one parent who also was or is an alcoholic.

· Roughly one in eight American adults is alcoholic or experiences problems due to the use of alcohol. The cost to society is estimated at approximately $85 billion each year.

· It is estimated that there are 26.8 million CoAs in the U.S.; 6.6 million are under the age of 18. A person may become an alcoholic without having a relative who is alcoholic. Similarly, most CoAs do not grow up to become alcoholic. CoAs are at greater risk of alcohol problems than are non-CoAs.

2. Children of alcoholics are more at risk for alcoholism and other drug abuse than children of non-alcoholics.

· Thirteen to 25% of all CoAs are likely to become alcoholics. Ten percent of the general population will experience problems related to alcohol consumption, including alcoholism.

· Physiological and environmental factors appear to place CoAs in greater risk of becoming alcoholic.

· Children of alcoholics are at increased risk for other drug use, especially as they approach late adolescence.

3. Alcoholism affects the entire family.

· Living with a non-recovering alcoholic in the family can contribute to

continued

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Children of Alcoholics: Facts and Figures *continued*

stress for all members in the family. Each family member may be affected differently. Not all alcoholic families experience or react to this stress in the same way.

4. Based on clinical observations and preliminary research, a relationship between parental alcoholism and child abuse is indicated in a large proportion of child abuse cases.

- Rates of parental alcoholism among families with reported child abuse range from 0%-92%.
- Assuming a population prevalence of alcoholism of 5%-10%, the majority of studies suggest increased prevalence of alcoholism among parents who abuse children.
- Existing research suggests alcoholism is more strongly related to child abuse than are other disorders such as parental depression.
- Although several studies report very high rates of alcoholism among the parents of incest victims, much additional research in this area is needed.

5. Children of alcoholics score lower on tests measuring verbal ability.

- CoAs score lower on tests that measure cognitive verbal skills. Their ability to express themselves may be impaired, which can impede their school performance, peer relationships, ability to develop and sustain intimate relationships, and hamper performance on job interviews.
- Low verbal scores, however, should not imply that CoAs are intellectually impaired.

6. Children raised in alcoholic families have different life experiences than children raised in non-alcoholic families.

- Children living in families with a non-recovering alcoholic score lower on measures of family cohesion, intellectual-cultural orientation, active-recreational orientation, and independence. They also experience higher levels of conflict within the family.
- When children of alcoholics are asked to choose between a drawing of a family talking and sitting close together, a family talking but not sitting close together, or a family that is not talking and not sitting close together, they describe their families as being in the latter category — not talking and not sitting close together.
- Healthy development requires mastering emotional and social tasks at various ages throughout childhood. These tasks include learning how to share, to interact, to engage in problem-solving, and to separate from parents. These skills are accomplished through play and fun activities, exposure to recreational and cultural opportunities, and building peer relationships. CoAs may be hampered by their inability to grow in developmentally healthy ways.
- Parental comorbidity (e.g., anxiety and depression) appears to be an important factor in determining the nature and extent of offspring problems and should be considered when attempting to discern the unique problems of children of alcoholics.
- Children raised in other types of dysfunctional families may be similar to children raised in alcoholic families.

7. Maintaining consistency around important family activities such as vacations, mealtimes, or holidays, is protective for some alcoholic families.

- If the active alcoholic is confronted with his or her problem, if family rituals or traditions are highly valued, if there are consistent significant others in the life of the child or children, and if there is moderate to high religious observance, children can be protected from the problems associated with growing up in an alcoholic family.

8. There is no clear relationship between being a child of an alcoholic and having an attention deficit disorder, hyperactivity, conduct disorder, or delinquency.

- There are not yet enough data to determine whether CoAs experiencing any of these problems do so because of the alcoholism in the family or because of other problems, or a cumulative result of many problems (e.g., being a CoA when parents are divorcing, reaching puberty, or experiencing some other forms of distress).
- Children with Fetal Alcohol Syndrome (FAS), caused by high levels of maternal alcohol consumption during pregnancy, suffer from a range of deficits that include dysmorphic facial features, growth retardation, intellectual impairment, and disrupted behavior patterns such as attention deficit disorders and hyperactivity. Fetal Alcohol Effects (less severe deficits) also are caused by alcohol consumption during pregnancy and the safest choice is not to drink during pregnancy.

9. Children of alcoholics exhibit symptoms of depression and anxiety more than children of non-alcoholics.

- Young children show symptoms of depression and anxiety such as crying, bedwetting, not having friends, being afraid to go to school, or having nightmares. Older youth may stay in their rooms for long periods of time and not relate to other children claiming they have "no one to talk to." Teenagers may show depressive symptoms by being perfectionistic in their endeavors, hording, staying by themselves, and being excessively self-conscious. Teenaged CoAs may begin to develop phobias.

10. Children of alcoholics often have difficulties in school.

- CoAs are more likely to be truant, drop out of school, repeat grades, or be referred to a school counselor or psychologist. This may have little to do with academic performance; rather, CoAs may have difficulty bonding with teachers, other students, and school; they may experience anxiety related to performance; those they already confront by living; or they may be afraid of failure. The actual reasons have yet to be determined.
- CoAs often believe that they will be failures even if they do well academically. They do not see themselves as successful.

11. Children of alcoholics have greater difficulty with abstraction and conceptual reasoning.

- Children of alcoholics often require very concrete instructions. Someone might say, "I want to be your friend" and a CoA might not know what that means. A person would have to say, "I want to be your friend and that means that you should call me whenever you want to, come to my house after school, and have dinner with me on Saturday nights."

12. Children of alcoholics may benefit from such guidance as:

- Helping them develop autonomy and independence.
- Helping them develop a strong social orientation and social skills.
- Helping them engage in acts of "required helpfulness."
- Helping them develop a close bond with a caregiver.
- Enabling them to negotiate successfully an abundance of emotionally hazardous experiences. Helping them to perceive their experiences constructively, even if those experiences cause pain or suffering. Helping them, early in life, to gain other people's positive attention.
- Helping them to develop and maintain a positive vision of life.

Editor's Note: These **Facts and Figures** are a *draft* of the information that will be included in the 1991 *Prevention Resource Guide* currently being developed by OSAP. Printed by permission of the Office for Substance Abuse (OSAP), U.S. Department of Health and Human Services.

RED LETTER DATES

November 9
Facilitator Training
Ramada Renaissance, Springfield, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951.

November 19-20
Planning for Youth Involvement in Communities of Color
YWCA of Metropolitan Chicago, Chicago, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951.

* November 28-30
Student Assistance Program Group Facilitator Training
Radisson Suites Hotel, Glenview, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951.

* December 3-7
Effective Black Parenting
Lincoln Plaza, Springfield, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951.

December 5-7
Third Annual Ohio Prevention & Education Conference
Hyatt Regency, Columbus, Ohio. Sponsored by the Ohio Department of Education and the Ohio Department of Alcohol and Drug Addiction Services, in cooperation with the Alcohol and Drug Abuse Prevention Association of Ohio. For more information, contact (614) 467-2843.

December 10-11
Baseline II: Community Team Building
Hyatt Regency, Chicago, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951.

* January 2-4, 1991
Preparing for the Drug (Free) Years
Chicago, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: December 3, 1990.)

* January 7
Baseline I for Youth
Mt. Vernon, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: December 10, 1990.)

* January 7-11
Effective Black Parenting
Hyatt Regency Chicago, Chicago, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: December 10, 1990.)

* January 11
Baseline for Youth
Hyatt Regency Chicago, Chicago, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, (800) 252-8951. (Deadline: December 10, 1990.)

* January 15-16
Active Parenting of Teens
Econolodge, Bloomington, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: December 15, 1990.)

January 16
Valuing Diversity in the Workplace
Lincoln Plaza, Springfield, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: January 4, 1991.)

* January 16-17
Student Assistance Program Team Training
Howard Johnsons, Springfield, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: December 17, 1990.)

January 23
Valuing Diversity in the Workplace
Chicago Historical Society, Chicago, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: January 4, 1991.)

January 24-25
Baseline II
Ambassador West Hotel, Chicago, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: January 4, 1991.)

* January 28
Baseline I for Youth
Lincoln Plaza, Springfield, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: January 4, 1991.)

January 30
Valuing Diversity in the Workplace
Holiday Inn, Mt. Vernon, Illinois. Sponsored by Prevention Resource Center (PRC). For registration packet, contact Training Registrar, PRC, (800) 252-8951. (Deadline: January 4, 1991.)

January 31-February 1
Statewide Meeting of the Illinois Department of Alcoholism and Substance Abuse Winter Prevention Providers Meeting
Ramada Renaissance, Springfield, Illinois. For registration contact Training Registrar at PRC, (800) 252-8951. (Deadline: January 11, 1991.)

February 24-27, 1991
VII Annual National Convention On Children of Alcoholics
Twin Towers Hotel and Convention Center, Orlando, Florida. For registration information, contact U.S. Journal Training Inc., (800) 851-9100.

* **Note:** *All trainings sponsored by Prevention Resource Center (PRC) during the training year 1990-1991 require written registration. Registration forms are contained in the PRC Training Catalog or may be obtained from the Training Registrar. Those trainings designated as "nomination only" require completion of an application/nomination form along with the standard registration form.*

Illinois Department of Alcoholism and Substance Abuse
will hold its
7th Annual Research Conference on Prevention
"Community Wellness"
May 9-10, 1991
Hyatt Regency, Oak Brook, IL

Call the Prevention Resource Center, Springfield, Illinois 800/252-8951 to be placed on the mailing list for further announcements and registration.

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Executive Director: Jackie Garner

Sheila Z. Beebe
Communications Specialist and Editor,
Prevention Forum

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Prevention Forum
Prevention Resource Center
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Springfield, Illinois 62704
(217) 525-3456

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Rituals, Traditions And Celebrations

Each family has a unique identity, made up of its particular faith, style of interaction, and family tradition. Thanksgiving, Hanukkah, Christmas, New Year's Eve, and Chinese New Year are all occasions to celebrate.

Many families incorporate alcoholic drinks into their holiday celebrations; other families do not use any. The way parents deal with alcohol during these and other occasions has a big impact on how their children will view and use alcohol as adults.

Celebrate with care.

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UNIVERSITY OF ILLINOIS
CHAMPAIGN IL 61820

ADDRESS CORRECTION REQUESTED

822 South College Street
Springfield, Illinois 62704

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